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Health system review

David Steel • Jonathan Cylus

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Health Systems in Transition

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United Kingdom (Scotland):

Health System Review 2012

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Contents

Preface v
Acknowledgements vii
List of abbreviations ix
List of tables, figures and boxes xiii
Abstract xv
Executive summary xvii

1. Introduction 1
1.1 Geography and socio-demography 1
1.2 Economic context 4
1.3 Political context 7
1.4 Health status 10

2. Organization and governance 17
2.1 Overview of the health system 18
2.2 Historical background 18
2.3 Organization 20
2.4 Decentralization and centralization 27
2.5 Planning 28
2.6 Intersectorality 32
2.7 Regulation 33
2.8 Patient empowerment 35

3. Financing 43
3.1 Health expenditure 44
3.2 Sources of revenue and financial flows 46
3.3 Overview of the statutory financing system 47
3.4 Out-of-pocket payments 51
3.5 VHI 53
3.6 Payment mechanisms 53

4. Physical and human resources **57**
4.1 Physical resources 57
4.2 Human resources 66

5. Provision of services **77**
5.1 Public health 77
5.2 Primary care 80
5.3 Specialized ambulatory inpatient care 83
5.4 Emergency care 86
5.5 Pharmaceutical care 89
5.6 Rehabilitation and intermediate care 93
5.7 Long-term care 95
5.8 Services for informal carers 98
5.9 Palliative care 99
5.10 Mental health care 101
5.11 Dental care 105

6. Principal health reforms **109**
6.1 Analysis of recent reforms 109
6.2 Conclusion and future developments 117

7. Assessment of the health system **119**
7.1 Stated objectives of the health system 119
7.2 Financial protection and equity in financing 121
7.3 User experience and equity of access to health care 122
7.4 Health outcomes, health service outcomes and quality of care 124
7.5 Health system efficiency 129
7.6 Transparency and accountability 131

8. Conclusions **133**

9. Appendices **135**
9.1 References 135
9.2 List of principal legislation 145
9.3 Useful web sites 146
9.4 HiT methodology and production process 147
9.5 The review process 150
9.6 About the authors 150

Preface

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- to assist other researchers in more in-depth comparative health policy analysis

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources,

including the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiTs and HiT summaries are available on the Observatory's web site (http://www.healthobservatory.eu).

Acknowledgements

The Health Systems in Transition (HiT) profile on Scotland was co-produced by the European Observatory on Health Systems and Policies and the King's Fund, which is a member of the network of National Lead Institutions (NLIs) that work with the Observatory on Country Monitoring.

The NLI network is made up of national counterparts that are highly regarded at national and international level and have particular strengths in the area of health systems, health services, public health and health management research. They draw on their own extensive networks in the health field and their track record of successful collaboration with the Observatory to develop and update the HiT.

The King's Fund is an independent charity working to improve health and health care in England, with the vision that the best possible health care is available to all. The King's Fund contributes to achieving this vision in two ways: by working to improve the way health care, and related social care, in England is organized, funded and delivered, and supporting individuals, teams and organizations to improve health and health care.

This edition was written by David Steel. It was edited by Jon Cylus, working with the support of Sarah Thomson of the Observatory's team at the London School of Economics and Political Science. Thanks are due to Lucy and Andrew Pearce for assistance with the production of tables and charts; and to Professor Peter Donnelly (University of St Andrews) and Dr Andrew Walker (University of Glasgow) for commenting on particular chapters.

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The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Ireland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The Observatory team working on HiTs is led by Josep Figueras, Director, Elias Mossialos, Martin McKee, Reinhard Busse and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Gabriele Pastorino. The production and copy-editing process of this HiT was coordinated by Jonathan North, with the support of Caroline White, Sophie Richmond (copy-editing), Steve Still (design and layout) and Mary Allen (proofreading).

List of abbreviations

Abbreviations	Description
A&E	Accident and emergency department
ADTC	Area Drugs and Therapeutics Committee
AER	Annual evaluation report
AfC	Agenda for Change
AHP	Allied health professional
BDA	British Dental Association
BMA	British Medical Association
CHCP	Community health and care partnership
CHD	Coronary heart disease
CHI	Community Health Index
CHP	Community health partnership
CHSCP	Community health and social care partnership
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
CPP	Community planning partnership
CSBS	Clinical Standards Board for Scotland
CVD	Cerebrovascular disease
DDRB	Doctors' and Dentists' Review Body
DTP	Diphtheria, tetanus and polio
ECS	Emergency care summary
ED	Emergency department
ETP	Electronic transfer of prescriptions
EU	European Union
FSA	Food Standards Agency
FTE	Full-time equivalent
GDC	General Dental Council
GDP	Gross domestic product
GDS	General Dental Service
GMC	General Medical Council

Abbreviations	Description
GMS/nGMS	General Medical Services/New General Medical Services Contract
GP	General practitioner
GPASS	General Practice Administration System for Scotland
GPhC	General Pharmaceutical Council
GVA	Gross value added
HEAT	Health, efficiency, access and treatment targets
HIS	Healthcare Improvement Scotland
Hib	*Haemophilus influenzae type b*
HLE	Healthy life expectancy
HPA	Health Protection Agency
HPS	Health Protection Scotland
HRG	Healthcare Resource Group
HSE	Health and Safety Executive
IASS	Independent Advice and Support Service
ICP	Integrated care pathway
ICU	Intensive care unit
IHD	Ischaemic heart disease
IM&T	Information management and technology
ISD	Information Services Division
ISP	Independent Scrutiny Panel
IT	Information technology
MenC	Meningococcal serogroup C
MMR	Measles, mumps and rubella
MoU	Memorandum of Understanding
MP	Member of Parliament (UK)
MRI	Magnetic resonance imaging
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSP	Member of Scottish Parliament
NES	NHS Education for Scotland
NHS	National Health Service
NHS QIS	National Health Service Quality Improvement Scotland
NIC	National Insurance Contribution
NICE	National Institute for Health and Clinical Excellence
NRAC	NHSScotland Resource Allocation Committee
NSS	NHS National Services Scotland
OECD	Organisation for Economic Co-operation and Development
OHE	Office of Health Economics
PACS	Picture Archiving and Communication System
PASS	Patient Advice and Support Service
PCV	Pneumococcal conjugate vaccine

Abbreviations	Description
PFI	Private finance initiative
PMS	Patient management system
PPP	Public–private partnership
PRO	Patient Rights Officer
PSD	Practitioner Services Division
QOF	Quality and outcomes framework
RPG	Regional Planning Group
RTT	Referral to treatment
SARS	Severe acute respiratory syndrome
SCI	Scottish Care Information
SEDS	Scottish Emergency Dental Service
SEPA	Scottish Environment Protection Agency
SHAS	Scottish Hospital (later Health) Advisory Service
SHC	Scottish Health Council
SIGN	Scottish Intercollegiate Guidelines Network
SMC	Scottish Medicines Consortium
SNP	Scottish National Party
SPPC	Scottish Partnership for Palliative Care
SPSO	Scottish Public Services Ombudsman
STUC	Scottish Trades Union Congress
VAT	Value added tax
VHI	Voluntary health insurance
WTE	Whole-time equivalent

List of tables, figures and boxes

Tables

		page
Table 1.1	Trends in population/demographic indicators, selected years	3
Table 1.2	Macroeconomic indicators, selected years	5
Table 1.3	Life expectancy at birth, selected years	11
Table 1.4	Main causes of death, selected years	12
Table 1.5	Maternal, child and adolescent health indicators, selected years	14
Table 2.1	Territorial NHS boards in Scotland	22
Table 3.1	Public health expenditure by programme, 2011/2012	45
Table 4.1	Health workers in Scotland, selected years (headcount)	67

Figures

		page
Fig. 1.1	Map of Scotland	2
Fig. 1.2	Population by age and sex, 2008 and 2033	4
Fig. 1.3	Scotland GDP weights, 2007	6
Fig. 2.1	The health system in Scotland	20
Fig. 3.1	Health spending per capita in the United Kingdom 2006/2007–2010/2011	44
Fig. 3.2	Distribution of spending by 14 territorial NHS boards, Golden Jubilee Hospital and State Hospital	46
Fig. 3.3	NHS financial flows	54
Fig. 4.1	Analysis of NHS estate (in %)	58
Fig. 4.2	Acute care hospital beds per 100 000 in selected countries, 1990 to latest available year	63
Fig. 4.3	Operating indicators	63
Fig. 4.4	Physicians per 100 000 population, selected countries, 1990 to latest available year	68
Fig. 4.5	Nurses per 100 000 population, selected countries, 2000 to latest available year	69
Fig. 4.6	Number of physicians and nurses per 100 000 population in the WHO European Region, latest available year	70
Fig. 4.7	Dentists per 100 000 population, selected countries, 1990 to latest available year	71
Fig. 5.1	Emergency care patient pathways	88
Fig. 5.2	Approval process for new medicines	92

Boxes

		page
Executive summary	Key strategic documents, 1997–2011	xxiv
Box 1.1	Risk factors affecting health status	13
Box 2.1	National health bodies: descriptions and budgets	25
Box 5.1	Organization of public health services	79
Box 5.2	National screening programmes	80
Box 5.3	Extended community pharmacy services	90
Box 6.1	Major policy statements and reforms, 1997–2011	110

Abstract

Over the last decade, Scotland's health system has increasingly diverged from the health system in England. Scotland has pursued an approach stressing integration and partnership among all parts of its NHS as opposed to an English approach in part driven by market forces. Comparatively fewer organizational and structural changes, in addition to consistent policy objectives, have provided a strong launching pad for achieving improvement. Substantial increases in funding have led to significant growth in the clinical workforce and numerous performance targets have been set to improve population health, the quality and outcomes of health care, and the efficiency of the health system. As a result, Scotland has made well-documented progress in terms of population health and the quality and effectiveness of care. However, a number of challenges remain. More progress is needed to close the gap in health status between Scotland and other developed countries, and to address persistent inequalities in health within Scotland. As in many other countries, increased fiscal pressures may make it difficult to maintain current levels of health care quantity and quality in future.

Executive summary

Scotland, the northernmost country in the United Kingdom, has a population of just over 5 million. Most people live in the "central belt", which includes the major cities of Glasgow and Edinburgh. Population density is low in comparison to the rest of the United Kingdom due to large remote and rural areas, notably in the Highlands. While the size of the population has remained relatively stable over the last 50 years, the proportion aged 65 years and over has grown significantly and is projected to increase further.

Scotland comprises around 10% of the United Kingdom economy. Its economy is dominated by the service sector, although energy is also important, with around 80% of United Kingdom oil and gas production attributable to Scotland. Gross value added (GVA) per head is 3% lower than the United Kingdom average. Public spending per capita is 21% higher in Scotland than in England. Since devolution in 1999, the Scottish Parliament and Government have been responsible for most areas of domestic policy, including the health system.

Life expectancy in Scotland has improved over the past decade but remains below that in the rest of the United Kingdom or western Europe. The three main causes of death are circulatory diseases, malignant neoplasms and chronic respiratory diseases. There are significant inequalities in health linked to socioeconomic status and risk factors such as smoking, alcohol consumption and poor diet, all of which are associated with deprivation.

Organization and governance

Health services in Scotland are financed almost entirely out of general taxation and are largely free at the point of need and available to all inhabitants. There is a very small independent health care sector, both private and non-profit-making.

Responsibility for health and for health services rests with the Scottish Cabinet Secretary for Health, Wellbeing and Cities Strategy, who is accountable to the Scottish Parliament. Supported by officials in the Scottish Government health and social care directorates, ministers set policy, oversee delivery of services by the NHS and regulate the small independent sector. Many of their functions are delegated to 14 integrated territorial NHS boards responsible for planning and delivering all health services – acute, primary and community – to the population in their areas.

Following devolution in 1999, NHS trusts were merged with boards and the purchaser–provider split introduced by the United Kingdom Government in the 1990s was dismantled. Each board delegates responsibility for delivery to operating divisions for acute services and to community health partnerships (CHPs) for community and primary care services. Nine national health bodies are responsible for services that are best provided by a single national organization, such as ambulance transport, information, education and training, and quality improvement.

There is strong accountability to the Scottish Parliament via ministers and through scrutiny by the parliamentary Health Committee, Audit Scotland and Healthcare Improvement Scotland within a broader National Performance Framework. Nevertheless, NHS boards have significant powers to determine the pattern of local care provision and to set local priorities. In recent decades, the extent and scope of patient and public involvement in the NHS has increased, with greater provision of information; the establishment of a national body dedicated to promoting and monitoring patient focus and public involvement; and the introduction of waiting time guarantees, stronger public participation on NHS boards and a patient experience programme.

Financing

Per capita public spending on health in Scotland is higher than in the rest of the United Kingdom (£2072 per year compared to £1926) but this differential has narrowed steadily in recent years. Since 2000, health spending has more than doubled in cash terms and increased by about 40% in real terms. It now accounts for 10% of gross domestic product (GDP) in Scotland and for 34% of the Scottish Government budget. In the current spending period (to 2015), health is the only sector with an increasing resource budget in cash terms. However, efficiency and productivity savings of at least 3% a year are needed to maintain financial balance in the face of inflationary, demographic and

clinical pressures. In 2011/12, three-quarters of the national health budget of £11.68 billion comprised core allocations to territorial and national boards, 12% was allocated for primary care contractor services, and the rest was earmarked for specific programmes. Allocation is based on a formula that reflects the relative needs of different geographical areas.

Around 83% of total health spending in the United Kingdom (separate Scottish data are not available) is publicly funded. The remainder comes from private voluntary health insurance (VHI, which covers 8.5% of the population in Scotland); user charges for dental care and ophthalmic services (prescription charges were abolished in Scotland in 2011); and direct payments for dental care, ophthalmic services and private treatment in independent or NHS facilities.

As there is no purchaser–provider separation, there are no contracts between boards and their operating divisions. Most primary care providers are independent contractors reimbursed for the services they provide to the NHS under the terms of their contracts. NHS boards directly employ, on a salaried basis, the staff working in hospitals and the community. They also manage, through CHPs, the contracts of independent contractors in primary care (general practitioners (GPs), dentists and community pharmacists).

Physical and human resources

The NHS estate comprises 4.6 million square metres of building space, 65% of which is accounted for by acute hospitals. In recent years there have been substantial programmes to dispose of surplus property and to build new facilities. Most NHS investment has been funded through public sector capital, but since the 1990s schemes have been developed to introduce private finance (which accounted for just over one-third of capital spending in 2010/11). Over the last 30 years there has been a substantial change in the infrastructure of the NHS as the number of hospitals and hospital beds has fallen steadily as a result of changes in clinical practice (such as the use of day surgery) and the development of services in the community. There has also been increasing investment in information management and technology (IM&T) – an area in which Scotland has a high reputation in the United Kingdom and internationally – with a strong focus in recent years on eHealth (patient-related systems). The size of the NHS workforce has grown by 14% since 2002, reflecting the substantial increase in funding. The NHS has been in the forefront of developing partnership working with staff, underpinned by a statutory duty of staff governance and a Staff Governance Standard.

Provision of services

Increasing emphasis has been given to NHS boards' lead role in improving population health, reflecting growing concern about Scotland's health problems. Key public health developments include a ban on smoking in public places, raising the age for purchasing tobacco from 16 to 18 and introducing a minimum unit price for alcohol (agreed in principle by the Scottish Parliament in 2012). Around 90% of patient contact is with primary care and most patient journeys begin and end in primary care, where GPs increasingly work as part of multidisciplinary teams involving nurses, midwives, health visitor, allied health professionals and managers. In recent years all the services provided by the NHS have been subject to change designed to improve their quality, effectiveness and efficiency. Common themes have been: improving health outcomes; improving access; providing services in the community in partnership with local authorities and the third and independent sectors; strengthening anticipatory and preventive care; involving patients and carers in decisions; and increasing productivity.

Principal health reforms

For the first few years after the election of a (United Kingdom) Labour government in 1997, broadly similar steps were taken in Scotland and England to dismantle the internal market that had been developed by the previous Conservative government. From 2000, however, the Labour/Liberal Democrat coalition in Scotland began to pursue an increasingly distinctive approach that stressed integration and partnership among all parts of the NHS, eschewing moves in England to revert to a market in health care delivery (particularly for elective care) involving both NHS and private sector providers. The election of a Scottish National Party (SNP) government in 2007 reaffirmed this policy and emphasized the continuation of a publicly provided service with a new focus on mutuality – involving patients and the public and NHS staff as "owners" and partners rather than just users and providers – and on quality as the driver of modernization and improvement.

Assessment of the health system

For the last 25 or so years, there has been a striking consistency in the objectives of successive Scottish governments regarding the health system: improving population health; improving the quality and outcomes of health care; and improving the efficiency and productivity of spending on health. Coupled with a relative lack of organizational turbulence, this stability in aims has provided a strong launching pad for achieving beneficial change. Progress has been made in relation to each of these aims. Health status has improved significantly, although a gap still persists between Scotland and other countries and among socioeconomic groups in Scotland. Scotland has led the way in taking forward many aspects of the quality agenda, with encouraging results, such as a reduction of over 9% in hospital standardized mortality ratios, and this has been evident in specific indicators for each of the "standard" dimensions of health care quality: person-centred, safe, effective, efficient, equitable and timely. There have also been improvements in all the main indicators of allocative and technical efficiency, and financial balance has been maintained at the same time as these improvements have been achieved. Comprehensive and rigorous analysis of the performance of the health system, including comparison with performance in other countries, lies beyond the scope of this report. Various attempts have been made to do this, but many of their conclusions have been challenged, not least due to the lack of comparable data of high quality.

Key strategic documents 1997–2011

The following documents are referenced throughout the HiT:

1997	**Election of Labour government in United Kingdom**		
		Designed to care: renewing the NHS in Scotland	Started process of dismantling internal market, including abolition of GP fundholding
1998		*Acute services review report*	Plan for acute services, focusing on access, quality and sustainability of services. Led to development of managed clinical networks
1999	**Devolution: election of Labour/ Liberal Democrat coalition in Scotland**		
2000		*Our national health: a plan for action, a plan for change*	Post-devolution action plan to use substantial increase in resources to build a modernized health system and improve Scotland's health
		Community care: a joint future	Promoting more effective joint working between NHS and local authorities
2003		*Partnership for care: Scotland's health White Paper*	Building on the 2000 plan, focus on patients and standards as drivers of change, on redesign of services and on health improvements. Led to abolition of NHS trusts and creation of CHPs
2005		*A national framework for service change in the NHS: building a health service fit for the future (Kerr report)*	Twenty-year plan to address Scotland's changing health needs, shifting balance of care towards community services, self-management and anticipatory care
		Delivering for health	Programme of action to deliver proposals in Kerr report
2007	**Election of minority SNP government**		
		Better health, better care action plan	Action plan to strengthen collaboration and integration through developing a mutual NHS, to tackle health inequalities and to improve quality of health care
2010		*The healthcare quality strategy for NHSScotland*	Strategy to put quality at the heart of the agenda and promote partnership among NHS staff, patients, carers and other agencies
2011	**Election of majority SNP government**		

1. Introduction

Scotland, the northernmost country in the United Kingdom, has a population of just over 5 million. Most people live in the "central belt", which includes the major cities of Glasgow and Edinburgh. Population density is low in comparison to the rest of the United Kingdom due to large remote and rural areas, notably in the Highlands. While the size of the population has remained relatively stable over the last 50 years, the proportion aged 65 years and over has grown significantly and is projected to increase further.

Scotland comprises around 10% of the United Kingdom economy. Its economy is dominated by the service sector, although energy is also important, with around 80% of United Kingdom oil and gas production attributable to Scotland. GVA per head is 3% lower than the United Kingdom average. Public spending per capita is 21% higher in Scotland than in England. Since devolution in 1999, the Scottish Parliament and Government have been responsible for most areas of domestic policy, including the health system.

Life expectancy in Scotland has improved over the past decade but remains below that in the rest of the United Kingdom or western Europe. The three main causes of death are circulatory diseases, malignant neoplasms and chronic respiratory diseases. There are significant inequalities in health linked to socioeconomic status and risk factors such as smoking, alcohol consumption and poor diet, all of which are associated with deprivation.

1.1 Geography and socio-demography

Scotland is the northernmost part of the United Kingdom (Fig. 1.1). Sharing a border with England to its south, it covers a land area of 77 925 square kilometres, almost one-third of the total land area of the United Kingdom.

In 2010 its population was 5 222 100, 8.4% of the total population of the United Kingdom[1] (GROS, 2011b). Population density is considerably lower than in the United Kingdom as a whole – 67 per square kilometre compared with 255 for the United Kingdom (ONS, 2011).

Fig. 1.1
Map of Scotland

Source: Author's own compilation.

There are marked differences in the geography and consequently in the population density of different parts of Scotland. The "central belt" is a relatively low lying and densely populated area that includes the two largest cities: Glasgow (593 000) and the capital Edinburgh (486 000). The Highlands – the northern part of Scotland – is a more mountainous area, which, although almost one-third of the Scottish land mass, has a relatively small population of just over 220 000 and a population density of only 9 per square kilometre.

[1] The source of all the population data in this section, unless otherwise stated, is the General Register Office for Scotland. It merged in April 2011 to become National Records of Scotland but still has its own website (www.gro-scotland.gov.uk).

A further feature to note is the large number of inhabited islands. To the north-west of the mainland lie the Western Isles (26 000); and to the north are two groups of islands: Orkney (20 000) and Shetland (22 000). There are also a large number of inhabited islands off the west coast, the largest of which is Skye.

The size of the population has remained relatively stable over the last 50 years (Table 1.1). It rose slightly between 1955 and 1975, declined over the next 30 years by 2.6%, and recently has started to increase. In 2010 it was at its highest level since 1977, mainly because immigration has exceeded emigration.

Table 1.1

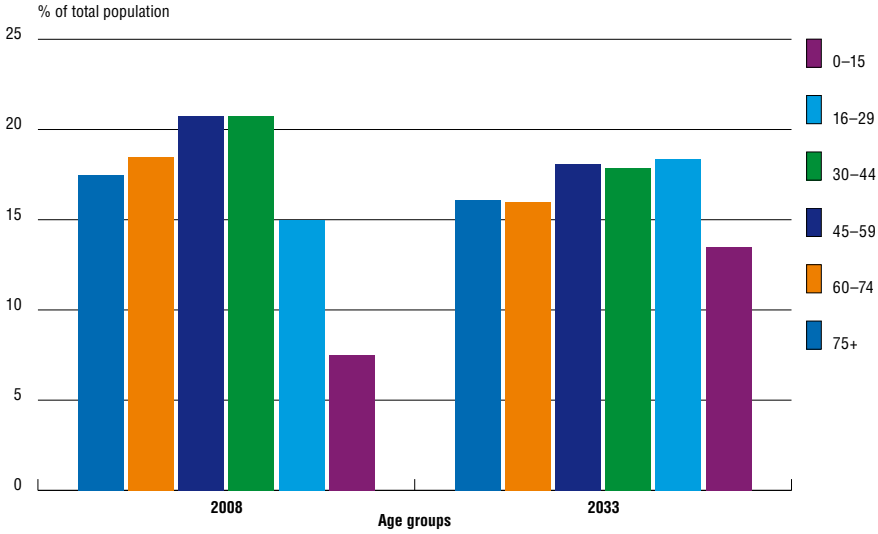
Trends in population/demographic indicators, selected years

	1975	1985	1995	2005	2010	2020	2035
Total population (in thousands)	5 232.4	5 127.9	5 103.7	5 094.8	5 222.1	5 486.0	5 755.0
Population, female (% of total)	51.9	51.8	51.9	51.8	51.5	51.2	50.9
Aged 0–14 (% of total)	24.6	19.4	18.9	17.0	16.3	16.4	15.3
Aged 65+ (% of total)	13.1	14.4	14.9	16.4	16.8	19.6	24.9
Aged 80+ (% of total)	1.9	2.9	3.2	4.1	4.4	4.7	8.1
Fertility rate (births per woman)	1.9	1.7	1.6	1.6	1.7	–	–
Birth rate, crude (per 1 000)	13.0	13.0	11.8	10.7	11.3	–	–
Death rate, crude (per 1 000)	12.1	12.5	11.8	10.9	10.3	–	–
Age dependency ratio 0–14 and 65+: 15–64 (%)	61	51	52	50	50	56	67

Sources: GROS, 2005, 2011b, 2011d.

There have been significant changes in the population age structure between 1975 and 2010 (Table 1.1 and Fig. 1.2), including a decline in the proportion of the population aged under 15 (from 24.6% to 16.3%) and an increase in the proportion aged 65 and over (from 13.1% to 16.8%). Both in absolute numbers and as a percentage of the total population, the group aged 80 and over has more than doubled during this period (from 99 900 to 229 800). Although comprising less than 2% of the current population, this age group makes intensive use of health services.

Fig. 1.2
Population by age and sex, 2008 and 2033



Source: SPICe, 2011a.

The Scottish population between 2010 and 2035 is projected to grow 10%, significantly less than in England (19%), and slightly less than in Wales (12%) and Northern Ireland (11%) (GROS, 2011d). Trends in the population age structure from 1975 to 2010 are expected to persist over the coming decades and have implications for the level and pattern of demands on services, recruitment and retention of staff, and funding of health care.

Scotland has a significantly smaller ethnic minority population than the United Kingdom as a whole (3.2% in comparison with 11.1%). The largest group is Asian (1.4%/5.4%); 0.4% are Black (2.8%) and 0.4% Chinese (0.4%).

1.2 Economic context

The Scottish economy makes up just under 10% of the total United Kingdom economy, although if Scotland's geographical share of oil is included, the size of the economy would increase by around 15%[2] (Scottish Government, 2011n). In 2009 its GVA was £102.6 billion. GVA per head was £19 744, which was

[2] The source of the economic data in this section, unless otherwise stated, is the *Overview of the Scottish Economy* by the Scottish Government's Chief Economic Adviser (Scottish Government, 2011o).

3% below the GVA per head of £20 357 for the United Kingdom as a whole. Macroeconomic indicators for Scotland from 1980 to the latest available year are shown in Table 1.2.

Table 1.2

Macroeconomic indicators, selected years

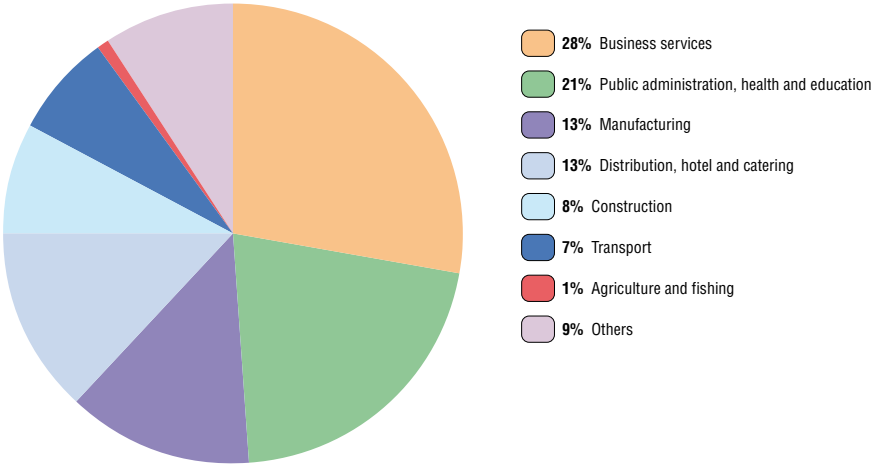
	1980	1990	1995	2000	2005	Latest available year
GVA at basic prices (£ millions)	na	43 230	55 883	68 181	87 841	102 552 (2009)
GVA at basic prices, PPP (current international US$) – United Kingdom PPP rate	na	70 788	87 156	107 189	138 077	159 677 (2010)
GVA at basic prices per capita	na	8 508	10 949	13 467	17 241	19 744 (2009)
GVA at basic prices per capita, PPP (current international US$) – United Kingdom figures	na	13 932	17 076	21172	27 101	30 742 (2010)
GDP average annual growth rate for the last 10 years (%) (Nominal Terms)	na	9.00	7.30	4.70	4.60	4.5 (2009)
Public expenditure (% of GDP)	na	na	na	na	47.80	53.1 (2010)
Value added in industry (% of GDP)	na	34	33	29	25	24 (2008)
Value added in agriculture (% of GDP)	na	3	3	2	1	1 (2008)
Value added in services (% of GDP)	na	64	64	69	74	75 (2008)
Labour force (16+) – figures are for March to May each year	na	na	4 003 705	4 014 470	4 106 182	4 261 701 (2011)
Labour force (16+) minus economically inactive – figures are for March to May each year	na	na	2 479 029	2 501 292	2 601 643	2703303 (2011)
Unemployment, total (% of 16+ total labour force) – figures are for March to May each year	na	na	8.40	7.60	5.70	7.6 (2011)
Poverty rate [a]	na	na	28	22	12	13 (2009)
Real interest rate (December of each year)	–1.40%	9.40%	3.70%	4.70%	3.50	–4.7% (Sept. 2011)
Official exchange rate (US$)	$2.2641	$1.6512	$1.5746	$1.6404	$1.8797	$1.5782 (Sept. 2011)

Source: Scottish Government.
Note: [a] Individuals living in households with income below 60% of the (inflation-adjusted) median income in 1998/99.

The last 30 years have seen steady growth in the economy, but generally at a lower rate than in the United Kingdom as a whole, averaging around 2% average annual growth in comparison with 2.5% in the United Kingdom. Recently, however, economic performance has been similar north and south of the border.

There has been a general shift over the past 30 years, as in the rest of the United Kingdom, from manufacturing to services, with the service sector now accounting for around 75% of output and 82% of employment. Key areas of growth in the services sector include public administration and banking and finance. Manufacturing currently contributes 13% to total output but only 7.5% of total employment (Fig. 1.3).

Fig. 1.3
Scotland GDP weights, 2007



Source: Scottish Government, 2011n.

Total public expenditure (i.e. expenditure by the United Kingdom Government, the Scottish Government and other public bodies including local authorities) in Scotland in 2010/2011 was £63.8 billion, 53.6% of GDP. The ratio of public spending to GDP has been 5–10% higher in Scotland than in the United Kingdom over the last decade. If the value added arising from activities associated with the production of oil and gas is included in the calculation of GDP, this reverses the position with Scotland 3–5% below the United Kingdom. Public spending per head of population is 21% higher in Scotland than in England.

At the 2010 Comprehensive Spending Review the United Kingdom Government set out plans for a period of significant fiscal consolidation, most of which (around 75%) is scheduled to come from cuts in public spending. The Scottish Government's budget, which funds the expenditure of the Scottish

Government and its associated departments and agencies (such as NHS boards and non-departmental public bodies) and its grants to local authorities was £35 billion in 2010/2011. However, the resource budget will be cut as a result by 12.1% in real (inflation-adjusted) terms and the capital budget by 35% over the period 2010/2011 to 2014/2015.

In 2011, 2.47 million people (70.9% of the population) were employed (the highest rate, along with England, among the countries of the United Kingdom). Unemployment was 7.6%, the same as for the United Kingdom as a whole, and the sixth lowest of the regions of the United Kingdom. It rose from its lowest recent level of 5.3% in 2006 to 8.9% in the middle of the recession but has fallen since mid-2010. However, the unemployment rate among young people aged 16–24 is significantly higher (19% in 2011) although slightly lower than in the United Kingdom as a whole.

The recent economic performance of the Scottish economy compares relatively well with the United Kingdom overall. However, the average figures conceal significant inequalities within Scotland. Unemployment rates are much higher in some areas of Scotland than in others, and the percentage of the population dependent on income support also varies widely between areas. These economic inequalities are closely linked to inequalities in health status (see McIntyre, 2007; see also Taulbut et al., 2011 for discussion of the impact of deprivation and de-industrialization on health).

Key features of the economy that are potentially significant for health and health care include the decline in heavy industries such as coal mining, iron and steel and ship building, which has left a legacy in terms of ill-health and male unemployment in certain areas of the country, growth in certain sectors such as energy – both oil and gas, where it is estimated that around 80% of United Kingdom production is attributable to Scotland (Kemp & Stephen, 2008), and renewables, where Scotland has 25% of Europe's offshore wind and tidal resources and 10% of Europe's wave energy potential – and the strength of the public sector, which comprises around one-quarter of total employment.

1.3 Political context

The Act of Union 1707 abolished the separate parliaments for Scotland and England, creating a single Parliament at Westminster in London. However, Scotland retained – and still has – many distinctive features, including a separate church and legal system. A form of administrative devolution for Scotland was

established in 1885, when the Scottish Office was created as a department of the United Kingdom Government, assuming responsibility for many of the issues that in England and Wales (the creation of a separate Welsh Office came only in 1964) were dealt with by Whitehall departments in London, such as health, education, justice, agriculture and fisheries (Kellas, 1989). It was headed by a Secretary of State for Scotland, who was a member of the United Kingdom Cabinet. He was supported by a number of junior ministers.

In 1979 a referendum was held on proposals by the then Labour government to establish a Scottish Assembly but, although a small majority voted in favour, the proposals did not obtain the support of 40% of the electorate, which was required before they could be implemented.

In 1989 a Scottish Constitutional Convention was established, comprising representatives of civic Scotland and some of the political parties, to draw up a blueprint for a directly elected Scottish Parliament with wide legislative powers. Its report formed the basis of proposals that were brought forward by the Labour government elected in 1997 and received overwhelming support in a referendum held in September 1997.

Following the passage of the Scotland Act 1998, the Scottish Parliament and the Scottish Executive (known as the Scottish Government since 2007) came into existence on 1 July 1999 and the powers relating to devolved matters were transferred to them from the Secretary of State for Scotland and other United Kingdom Ministers (Keating, 2010).

Elections to the Scottish Parliament are conducted on the basis of a mixed system combining the traditional first-past-the-post system (to elect 73 constituency members) and a form of proportional representation called the Additional Member system (to elect 56 regional members) (SPICe, 2011b).

The Scottish Parliament has full legislative competence (that is, it can pass both primary and secondary legislation) across a wide range of devolved subjects. The Act does not set these out; instead it lists "reserved matters" for which the United Kingdom Parliament retains responsibility. For this reason 59 Members of Parliament (MPs) representing Scottish constituencies sit in the United Kingdom Parliament. Reserved matters include: constitutional issues; foreign and defence policy; fiscal and monetary policy; immigration; energy; social security; and a few health issues (see Chapter 2).

The Scottish Government is the devolved administration and is led by a First Minister, elected by the Scottish Parliament, who appoints a Cabinet of Scottish Ministers. Currently there are eight cabinet secretaries (one of whom is the

Cabinet Secretary for Health, Wellbeing and Cities Strategy, who is also Deputy First Minister). They are supported by a further 10 ministers. Devolved issues include: health and social work, education and training, housing, planning, tourism, economic development, some aspects of transport, agriculture, forestry and fishing, the environment, law and home affairs (including the courts, police and fire services), and sport and the arts.

The Scottish Parliament also has limited powers to vary the basic rate of income tax by up to three percentage points but these have never been used. The budget for devolved matters is provided as a block grant by the Treasury in London (described in more detail in section 3.3.3 *Pooling and allocation of funds*).

The Scottish Government maintains close working relationships with the United Kingdom Government and the devolved administrations in Wales and Northern Ireland. The statutory framework is underpinned by a Memorandum of understanding (MoU) and four concordats (on international relations, the European Union (EU), financial assistance to industry, and statistics) (United Kingdom Government, 2010). There are also more detailed bilateral concordats with individual Whitehall departments. The MoU created a Joint Ministerial Committee to enable ministers of the four administrations of the United Kingdom to meet and discuss policy issues together. Within the United Kingdom Cabinet Scotland continues to be represented by a Secretary of State who heads a small Scotland Office.

In August 2007 the minority SNP government launched a "national conversation" on Scotland's future, following which it promised to hold a referendum on the options (Scottish Government, 2007b). This prompted all the parties in the Parliament apart from the SNP, and with the support of the United Kingdom Government, to set up a Commission on Scottish Devolution. Its review of the first 10 years of devolution, published in June 2009, concluded that it had been a "remarkable and substantial success" but recommended changes to extend the range of devolved issues and increase financial accountability by replacing the Parliament's existing tax raising powers with new powers to levy a Scottish income tax of up to 10 percentage points and to devolve various other taxes such as Stamp Duty, Land Tax and Landfill Tax, making corresponding reductions in Scotland's block grant and by giving Scottish ministers borrowing powers (Calman, 2009). These recommendations were accepted by the then Labour government in November 2009 and taken over by the coalition government that took office in May 2010. They are incorporated in the Scotland Act 2012 and will come into force in 2016. Following its election

victory in 2011, the SNP government – now with an overall majority in the Scottish Parliament – promised to hold an independence referendum during its current term (i.e. before 2016, likely to be in 2014).

The electoral system for the Scottish Parliament was in part designed to prevent any one party achieving hegemony, both to promote a more consensual approach to policy-making and to avoid some of the problems that were considered to have arisen as a result of Labour's one-party dominance of Scottish local government. This worked for the parliaments elected in 1999, 2003 and 2007, in which no party had an overall majority. In the first two, the government comprised a Labour/Liberal Democrat coalition and in the third a minority SNP administration. In 2011, however, the SNP won an overall majority of nine.

A detailed discussion of Scottish politics is beyond the scope of this report. However, two points are relevant. First, the centre of gravity in Scottish politics is further to the left than in England. Second, devolution has significantly increased the "politicization" of the NHS in two ways. First, there is much greater parliamentary scrutiny. Previously Scottish affairs attracted little interest in the United Kingdom Parliament, and Scottish health even less; now, health is the biggest part of the Scottish Parliament's remit – accounting for over 30% of the budget – and, both in the chamber and in committees, is very important. Second, although strictly health issues are relevant only to the Scottish parliamentary elections, they also feature prominently in debate in Scotland for United Kingdom general elections and Scottish local government elections. This means that those running the NHS operate in almost a permanent electoral context.

1.4 Health status

Scottish people are in poorer health in comparison with other parts of the United Kingdom, including those with similar history and socioeconomic characteristics, and most other EU countries (Taulbut et al., 2011). In recent years there have been significant improvements but most other western European countries have experienced faster increases in the health of their populations. Moreover, the gap in health between the most and least deprived areas has widened.

Life expectancy at birth for both men and women in Scotland has improved over the past 30 years (Table 1.3), but it remains below the average life expectancy for people in the United Kingdom as a whole. For Scottish

men, average life expectancy at birth in 2008 was 75.3 years, compared with 77.7 years for the United Kingdom. This difference has widened slightly over the last decade; in the early 1990s it was less than two years. For Scottish women, the average life expectancy at birth in 2008 was 80.1 years compared with 81.9 years in the United Kingdom. This gap has remained stable since the early 1990s.

Table 1.3

Life expectancy at birth, selected years

	1981	1991	2001	2005	2008
Life expectancy at birth, male	69.1	71.4	73.3	74.6	75.3
Life expectancy at birth, female	75.3	77.1	78.8	79.6	80.1

Source: OHE, 2011.
Note: Figures are based on deaths and populations in a three-year period surrounding the year shown.

The gap between men and women has narrowed but only very slightly. However, since 1999 life expectancy in males living in the most deprived 15% of areas in Scotland has increased by 1.4 years while life expectancy for males living in the rest of Scotland has increased by 2.1 years. The corresponding figures for women are 1.2 years and 1.6 years respectively. At present Scotland has the lowest life expectancy of all western European countries. Projections for the next two decades forecast a widening gap between the most and least deprived areas and a fall in Scotland's position in the European "league table" as some areas of Eastern Europe achieve a step change improvement in health (Scottish Government, 2010g).

The widening gap is even more apparent with regard to healthy life expectancy (HLE) – the length of time an individual might expect to live in good health. Between 1999 and 2008, HLE increased by around three years for men and over two years for women. However in 2008 a man living in the most deprived 15% of areas in Scotland could expect to live in good health for 10.5 years less than the national average; the equivalent gap for women was 8.6 years. The way in which HLE is assessed was changed in 2009 (to accord with practice elsewhere in the EU) and it is not possible therefore to map this trend. However in 2009/2010, HLE of those living in the most deprived decile was 22.5 years lower for males and 22.1 years lower for females than the HLE of those living in the least deprived decile. Since 1999, residents of the poorest 15% of areas have seen a gain of 2.1 years for men and 1.1 years for women, whereas the increases in the rest of Scotland for men and women have been 2.9 and 2.3 years respectively (Scottish Government, 2011c).

There have been numerous initiatives over recent decades that have had positive effects on health in Scotland and there have been significant reductions in mortality from many of the most significant causes of death (see Table 1.4). Data published by the Scottish Public Health Observatory show that, over the last 50 years, mortality from all causes has fallen in Scotland in line with trends across the rest of western Europe. However, while mortality rates for Scottish children are close to the western European average, mortality among working-age Scots, both men and women, is the highest in western Europe and has been since the late 1970s (Scottish Government, 2010g).

Table 1.4

Main causes of death, selected years

Causes of death (ICD-10 classification	2000	2005	2010
Circulatory diseases	23 657	20 060	16 517
Ischaemic heart diseases (I20–I25)	12 412	10 331	8 138
Cerebrovascular diseases (I60–I69)	6 803	5 789	4 764
Malignant neoplasms (C00–C97)	14 958	15 135	15 323
Chronic respiratory diseases (J00–J99)	6 547	7 093	6 896
Mental and behavioural disorders (F00–F99)	2 309	2 454	3 459
Digestive diseases (K00–K93)	2 922	3 221	3 108
Infectious and parasitic diseases (A00–B99)	476	719	751
Suicide (X60–X84)	648	547	569

Source: GROS, 2011a.

The three main causes of death are circulatory diseases (ischaemic heart diseases (IHD) and cerebrovascular diseases), malignant neoplasms (lung, colorectal and breast cancer being the most common in that order), and chronic respiratory diseases (chronic obstructive pulmonary disease, emphysema and asthma, and pneumonia). Part of the difference in life expectancy between Scotland and the rest of the United Kingdom is a reflection of the high level of mortality from IHD in Scotland. In 2008, the age-standardized mortality rate from IHD was 16% above the United Kingdom figure for men and 19% for women (ONS, 2010). However, over the last 30 years there has been substantial progress in reducing deaths from IHD. Similar progress has been made in relation to stroke (GROS, 2011a). Although the gap is narrowing, mortality rates from both causes in Scotland remain among the highest in western Europe.

In relation to specific cancers, trends vary significantly. Scotland has the highest rates of oesophageal cancer in western Europe for both men and women (Scottish Government, 2010g). However, while lung cancer mortality rates for males and females remain among the highest in western Europe, the male

rate has reduced significantly since the mid 1970s and is moving closer to the average, reflecting efforts to reduce smoking rates. Rates of colorectal cancer mortality (for males and females) and breast cancer mortality, although still relatively high, have been falling and are converging towards the western European mean. The last 20 years have also seen significant improvements in survival from cancer (Scottish Government, 2011c).

Mortality rates from chronic obstructive pulmonary diseases such as chronic bronchitis are among the highest in western Europe, although again the position is improving.

In the opposite direction, mortality rates from chronic liver diseases such as those caused by excess alcohol consumption have risen steeply since the early 1990s for males and females, and are close to the highest in western Europe. Liver cirrhosis rates are two and half times higher than in England (Scottish Government, 2007a).

There are therefore encouraging trends in reducing the incidence of premature deaths from a number of causes, and much of this can be attributed to efforts by successive governments on preventive action, and on improved screening and treatment. However, overall health remains poor in relation to other countries and health inequalities between areas and groups of the population are widening. This reflects a complex interplay of factors relating to life circumstances (income, employment, housing, etc.) and lifestyle (smoking, alcohol consumption, diet and physical activity), on which the data in Box 1.1 show that major challenges remain, despite noted progress.

Box 1.1
Risk factors affecting health status

Smoking	1995–2010: proportion of adult smokers declined from 35% to 25%
Alcohol consumption	2003–2010: proportion drinking in excess of recommended weekly alcohol limits declined from 28% to 22%
Diet	2010: 22% of adults and 12% of children met the recommended daily intake of fruit and vegetables
Physical activity	2010: 39% of adults met recommended levels and 72% of children (including school-based activity)
Weight	1995–2010: proportion of adults 16–64 overweight or obese (BMI<=25) increased from 52% to 63%

Source: Scottish Government, 2011j.

1.4.1 Maternal and child health

In 2009 there were 59 046 live births (GROS, 2011c). The birth rate fell steadily from a peak in the 1960s but recently has started to increase. As Table 1.5 indicates, the rate of teenage pregnancy is over 50 per 1000 women aged 15–18, among the highest in western Europe, but with a small but consistent fall since 2005. As in other countries, rates of perinatal, infant and maternal mortality have reduced to very low levels. The rate of terminations has risen steadily over the last 30 years. There has also been an upward trend in diagnoses of most sexually transmitted infections. Additionally, each year about 3000 babies are born with a birthweight of less than 2500 g, twice as many in deprived as in affluent areas (Scottish Government, 2011c).

Table 1.5

Maternal, child and adolescent health indicators, selected years

Indicator	1980	1990	1995	2000	2005	2009
Adolescent [a] pregnancy [b] rate [c]	na	na	54.0	55.6	56.7	52.8
Adolescent birth rate	na	na	37.3	36.7	34.8	32.1
Termination of pregnancy (abortion) rate [d]	7.3	9.1	10.1	11.1	12.0	12.6
Perinatal and neonatal mortality rate	27.5	18.3	18.5	16.4	15.3	14.2
Postneonatal mortality rate	4.3	3.3	2.2	1.8	1.7	1.2
Infant mortality rate	12.1	7.7	6.2	5.7	5.2	4.0
Under-5 mortality rate	–	–	7.5	6.5	6.0	4.1
Maternal mortality rate 2000–2010 [e]	–	–	–	8	4	6
Syphilis [f] incidence rate [g, h]	2.7	0.5	0.1	0.4	3.7	3.4
Gonococcal infection incidence rate [h]	91.8	16	7.7	13.8	16.4	15.3

Notes :
[a] Includes all pregnancies in women aged under 20, based on age at conception and year of event (i.e. birth or abortion);
[b] Data source: GROS (2011c) from official birth registration and notifications to the Chief Medical Officer of abortions performed under the Abortion Act 1967; ISD (2011a);
[c] Rate per 1 000 women aged 15–19;
[d] Notifications to the Chief Medical Officer of abortions performed under the Abortion Act 1967. Includes terminations carried out in Scotland for women of all ages, based on the age at time of termination. Rate per 1 000 women aged 15–44. Source: ISD (2011a);
[e] Source: GROS from official registration, classified using ICD9 codes (630–676) and ICD10 codes (O00–O99) – "Pregnancy, childbirth and the puerperium" chapter;
[f] Includes infectious syphilis;
[g] Source: ISD (2010: Table 1b);
[h] Rate per 100 000 population.

1.4.2 Immunization and screening

Scotland has a comprehensive programme of immunization, focusing on infants, children, older people and health care staff with very high levels of uptake. By 24 months, 96–98% of children have completed a course of core vaccinations (target 95%) and the MMR target of 95% of one dose by 5 years

has been exceeded in each year since 2008 (ISD, 2011d). For older people, the WHO target of 75% uptake of seasonal flu vaccination has been achieved in all but the pandemic flu year of 2009 (Scottish Government, 2011l).

There are seven national screening programmes: bowel, breast and cervical cancer, diabetic retinopathy, newborn blood spot, pregnancy, and newborn hearing. In 2010/2011 the proportion of the target population screened for cancers was breast 75% (target 70%), cervical 74% and bowel 54% (target 60%) (ISD, 2011p, 2011q, 2012d).

1.4.3 Dental health

Oral health for adults in Scotland has improved steadily over the last few decades. In 1972, 44% of adults were identified as having no natural teeth but this had fallen to 12% by 2008 (Scottish Government, 2010l). Scotland still lags behind other areas of the United Kingdom (overall 6%) (NHS Information Centre, 2009). Of particular concern is the oral health of children. Until recently little progress had been made in reducing the proportion of 5-year-olds showing signs of dental decay – with the rate at around 55% until 2005 – but since then concerted efforts have meant that the target of reducing this to 40% has been achieved. Again, the incidence of dental disease correlates closely with deprivation: for example, children from the most deprived areas have substantially more decay (SDECC, 2010).

2. Organization and governance

Health services in Scotland are financed almost entirely out of general taxation and are largely free at the point of need and available to all inhabitants. There is a very small independent health care sector, both private and non-profit-making. Responsibility for health and for health services rests with the Scottish Cabinet Secretary for Health, Wellbeing and Cities Strategy who is accountable to the Scottish Parliament. Supported by officials in the Scottish Government health and social care directorates, ministers set policy, oversee delivery of services by the NHS and regulate the small independent sector. Many of their functions are delegated to 14 integrated territorial NHS boards responsible for planning and delivering all health services – acute, primary and community – to the population in their areas.

Following devolution in 1999, NHS trusts were merged with boards and the purchaser–provider split introduced by the United Kingdom Government in the early 1990s was dismantled. Each board delegates responsibility for delivery to operating divisions for acute services and to CHPs for community and primary care services. Nine national health bodies are responsible for services that are best provided by a single national organization, such as ambulance transport, information, education and training, and quality improvement.

There is strong accountability to the Scottish Parliament via ministers and through scrutiny by the parliamentary Health Committee, Audit Scotland and Healthcare Improvement Scotland within a broader National Performance Framework. Nevertheless, NHS boards have significant powers to determine the pattern of local care provision and to set local priorities. In recent decades, the extent and scope of patient and public involvement in the NHS has increased, with greater provision of information; the establishment of a national body dedicated to promoting and monitoring a patient focus and public involvement; and the introduction of waiting time guarantees, public participation on NHS boards and a patient experience programme.

2.1 Overview of the health system

Health services in Scotland are financed almost entirely out of general taxation and are thus largely free at the point of need and available to all inhabitants. There is a small independent health care sector, both private and non-profit-making. Scottish ministers are responsible for setting policy, overseeing delivery of services by the NHS and regulating the small independent sector. Many functions are delegated to 14 integrated territorial NHS boards responsible for planning and delivering all health services – acute, primary and community services – to the population in their areas. There are also nine national health bodies responsible for services that are best provided by a single organization, such as ambulance transport, information, education and training, and quality improvement. There is no purchaser–provider split. NHS boards directly employ on a salaried basis the staff working in hospitals and the community. They also manage, through CHPs, the contracts of independent contractors in primary care such as GPs, dentists and community pharmacists, reimbursing them for the work they do for the NHS.

2.2 Historical background

For much of the post-war period, the management and organization of the NHS in Scotland were broadly similar to elsewhere in the United Kingdom, and changes in organizational structure in Scotland tended to reflect the changes in the rest of the country (Woods & Carter, 2003).

Until 1999, health care polices in Scotland were determined by the Scottish Office, a department of the United Kingdom Government, and headed by the Secretary of State for Scotland, a member of the United Kingdom Cabinet. As a result, while there was some divergence in policy, there were also limits on Scotland's autonomy (Hunter, 1982; Keating & Midwinter, 1983; Hunter & Wistow, 1987).

From 1974 until the early 1990s, 15 geographically based health boards had overall responsibility for the management of health services within their areas. They were allocated funds by the Scottish Office and were accountable to the Secretary of State for the use of these funds, although in practice they were accountable to one of the junior ministers, who combined the health portfolio with other responsibilities such as education or home affairs. The combination within health boards of responsibility for hospital and community services and

for primary care differed from the arrangements in England (although the latter were provided as in the rest of the United Kingdom by independent contractors) as did the absence of a regional tier of management.

In the early 1990s this hierarchical model of organization for the NHS was replaced by one based on market principles, the so-called "internal market". This new system was announced at the same time in Scotland as in other areas of the United Kingdom, but its implementation was significantly slower, reflecting a general reluctance towards adopting policies "imposed" by a Conservative government in London. Health boards became "purchasers" of health care for their resident populations, and hospitals and community health services, which had previously been directly managed by the boards, were now established as separate NHS trusts that supplied services to the boards. In the same vein, GPs were able to become fundholders who could purchase a limited range of services from NHS trusts on behalf of their patients. At the time of the 1992 general election there were only 2 NHS trusts in Scotland (compared with almost 60 in England) but by the end of 1996 there were 47, covering all of mainland Scotland; by the same date 43% of the Scottish population were registered with a GP fundholder.

In 1997 a Labour government that was committed to abolishing this internal market replaced the Conservative government in London. Although initially the Scottish Office retained the organizational distinction between health boards and NHS trusts, there was increased emphasis on partnership and on the need for different organizations within the NHS to work together in a more integrated manner. The number of NHS trusts was reduced, with generally a single acute and a single primary care trust in each board, and fundholding by GPs was abolished.

Following devolution, the Scottish Executive announced in 2000 the unification of health boards and NHS trusts, a process that was completed by 2004. The number of area boards was reduced to 14 in 2006 as a result of the dissolution of Argyll and Clyde Health Board following financial difficulties.

The SNP government that took office as a minority administration from 2007 to 2011, and with an overall majority since 2011, maintained the NHS structure established by the previous administration, which is described in the next section.

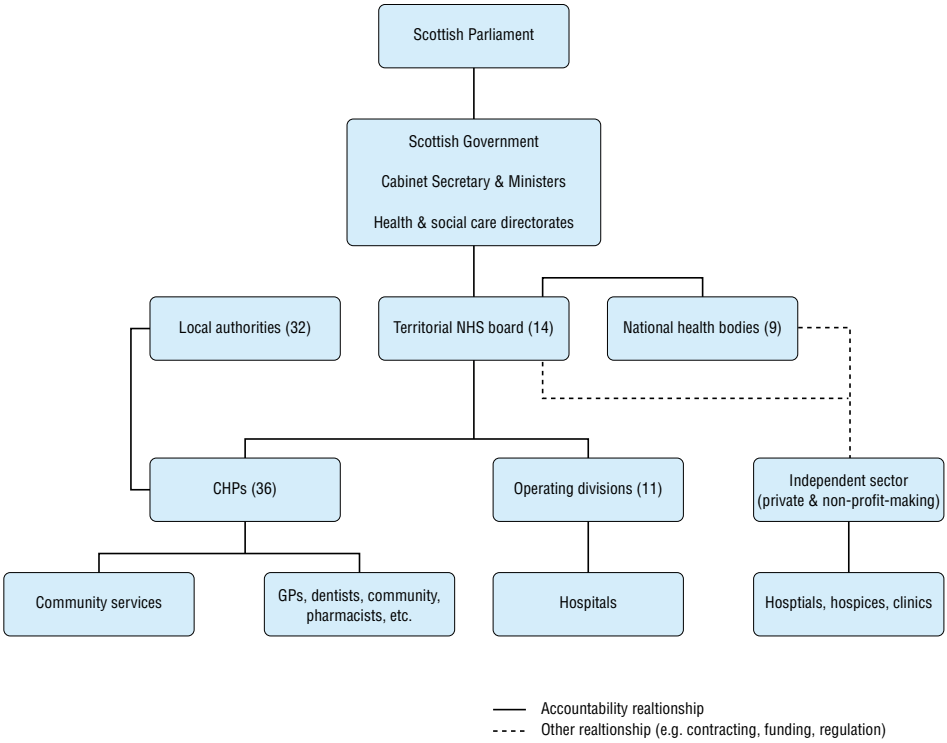
2.3 Organization

2.3.1 United Kingdom Government

The United Kingdom Government, through Her Majesty's Treasury, provides an overall budget to the Scottish Parliament. The (United Kingdom) Department of Health is responsible for those functions reserved to it by the Scotland Act 1998, such as regulation of most health care professions, and is the lead department for the United Kingdom in relationships with the EU and international organizations such as WHO. Arrangements are in place for regular liaison at ministerial and official level between the Department of Health and its counterparts in the devolved administrations (Greer & Trench, 2010).

Fig. 2.1 provides an overview of the structure of the health care system in 2011.

Fig. 2.1
The health system in Scotland



2.3.2 Scottish Parliament

The Parliament takes a close interest in health, which accounts for 30% of the Scottish budget. There is a standing Health Committee which conducts inquiries into specific issues and has a key role in health legislation. Health issues also feature prominently on the agendas of the Audit Committee and the Public Petitions Committee.

2.3.3 Scottish Government

Cabinet Secretary for Health, Wellbeing and Cities Strategy
The Cabinet Secretary responsible for health care is the Cabinet Secretary for Health, Wellbeing and Cities Strategy (who is also Deputy First Minister). Her responsibilities also include social care, equalities and anti-poverty measures and sport. She is assisted by two ministers: one for public health, the other for the Commonwealth Games (due to be held in Glasgow in 2014) and sport.

The Scottish Government, subject to the approval of the Scottish Parliament, determines how the overall budget should be split between the NHS and other services such as education and transport. It is then the responsibility of the Cabinet Secretary, advised by the Scottish Government health and social care directorates, to decide how best to deploy the funds allocated for health and social care in Scotland, and to oversee their use.

Scottish Government directorates for health and social care
The Scottish Government directorates for health and social care have responsibility for health and social care policy, the management of the NHS and oversight of social care services (provided by local authorities and the private and third sectors). The directorates are headed by a Director-General who is also Chief Executive of the NHS. Within the directorates there are professional advisers including a Chief Medical Officer, a Chief Dental Officer, a Chief Nursing Officer and a Chief Pharmacist.

In relation to health, the role of the centre has been defined (Scottish Executive, 2003) as being to:

- determine national objectives and policies for health protection, health improvement and health services, setting targets and offering guarantees on behalf of patients;
- provide a clear statutory and financial framework for the NHS;
- hold the NHS to account for its performance against national priorities and targets;

- intervene when serious problems or deficiencies in service arise that are not being resolved quickly enough at local level.

2.3.4 NHS boards

The majority of the health budget is provided to 14 geographically based NHS boards that are responsible for planning and delivering services to meet the health care needs of their populations (Table 2.1).

Table 2.1
Territorial NHS boards in Scotland

	Pop. (2010)	Budget (2010/2011) £ million	Staff headcount (2011)
NHS Ayrshire and Arran	366 900	589	10 289
NHS Borders	112 900	171	3 151
NHS Dumfries and Galloway	148 200	246	4 343
NHS Fife	364 900	519	8 571
NHS Forth Valley	293 400	406	5 867
NHS Grampian	550 600	704	13 932
NHS Greater Glasgow and Clyde	1 203 900	1 955	38 538
NHS Highland	310 800	497	8 546
NHS Lanarkshire	562 500	824	11 516
NHS Lothian	836 700	1 063	21 771
NHS Orkney	20 100	32	526
NHS Shetland	22 400	38	571
NHS Tayside	402 600	614	13 521
NHS Western Isles	26 200	60	1 023

Source: GROS, 2011b; Scottish Government, 2012e.

Each board comprises a non-executive chair, appointed by ministers after open competition, varying numbers (currently between 9 and 23) of non-executive directors (some lay, appointed by ministers after open competition; others, also appointed by ministers, but as representatives of particular stakeholder interests such as the board's employees, the area clinical forum, and each of the local authorities in the board's area), and normally around six executive directors appointed by virtue of their position (e.g. Chief Executive, Medical Director, Nursing Director, Finance Director, Director of Public Health).

In two areas – Fife, and Dumfries and Galloway – election of a proportion of the non-executive directors was piloted in 2010 to ascertain whether having a directly elected element improves public participation. In these boards elected

members and nominated councillors now form a majority. In two other areas – Grampian and Lothian – alternative pilots are being pursued to widen the range of applicants coming forward through the public appointments system. Elections will only be rolled out to the rest of Scotland once a full independent evaluation has been completed and the necessary legislation enacted. An interim evaluation was published in 2011 (Greer et al., 2011).

Although there is no purchaser–provider split in Scotland and unified, integrated boards combine these roles, the focus of boards is on strategic leadership and performance management of the entire local NHS system. Within each board, responsibility for delivery is delegated to operating divisions for acute services and to CHPs for community and primary care services.

Operating divisions, headed by a Chief Operating Officer leading a multi-professional management team in each NHS board, have taken on the role of the former NHS trusts that were responsible for acute care. They have specific delegated authority to act without constant reference to the board, backed by formal schemes of accountability.

CHPs are committees of each NHS board responsible for planning and delivering primary care and community-based health services. The NHS Reform (Scotland) Act 2004 required boards to establish one or more CHP in their area to bridge the gap between primary and secondary care and between health and social care. At present there are 36 CHPs in Scotland, at least one in each board area and one or more CHPs share the same geographical boundary with local authorities.

Boards and their partners have established different arrangements across Scotland, which means there are significant differences in the size, role, function and governance arrangements of individual CHPs. Broadly two types have evolved: 29 health-only structures, known as CHPs, and 7 integrated health and social care structures, known as community health and care partnerships (CHCPs) or community health and social care partnerships (CHSCPs). Irrespective of type, all CHPs are statutory committees or sub-committees of NHS boards and thus accountable to their respective board, although the integrated CHPs have dual accountability to the relevant local authority as well.

Membership of CHPs was defined by the Scottish Government and must include the CHP general manager, a GP, a nurse, a doctor who does not provide primary medical services, a councillor or an officer of the local authority, a staff representative, a member of the Public Partnership Forum

(see section 2.8.5 *Public participation*), a community pharmacist, an allied health professional, a dentist, an optometrist, and a member of a health-related voluntary sector organization.

Following a report by Audit Scotland that the impact of CHPs had been hampered by a "cluttered institutional landscape" and complex governance and accountability arrangements, the Scottish Government in 2012 issued consultation proposals to replace CHPs with health and social care partnerships jointly accountable to local authorities (Audit Scotland, 2011a; Scottish Government, 2012c).

2.3.5 National health bodies

In addition there are nine national bodies responsible, in partnership with the territorial boards, for services that are best provided on an all-Scotland basis. These are listed in Box 2.1. The composition and accountability of these bodies are broadly the same as for the territorial boards.

These bodies are often described as special NHS boards. Formally this term applied only to the six that were set up under secondary legislation and not to HIS, MWC and NSS, which, due to their functions and history, were created in primary legislation.

The figures for HIS in Box 2.1 are for its predecessor body, NHS Quality Improvement Scotland (see section 2.7).

2.3.6 Local authorities

Although not coterminous, 32 local authorities work closely with NHS boards to ensure the effective delivery of a range of community health and social work services. This relationship is now formalized through representation of each local authority on the board of each relevant NHS board, through local authority membership of all CHPs and joint accountability of CHCPs and CHSCPs, and through some joint appointments (e.g. in Glasgow the Director of Public Health works for both the NHS Board and the City Council). Various initiatives have been taken to promote greater integration of health and social care, including the designation in Highland from April 2012 of the NHS board as lead agency for adults and Highland Council for children and families.

Box 2.1

National health bodies: descriptions and budgets

Healthcare Improvement Scotland (HIS)
Responsible for developing advice, guidance and standards on effective clinical practice, driving and supporting improvement, and providing assurance on quality and safety through scrutiny and reporting on performance.
Budget 2010/2011: £17.5m; staff headcount (2011): 297

Mental Welfare Commission for Scotland (MWC)
Responsible for safeguarding the rights and welfare of people with a learning disability, mental illness or other mental disorder
£3.7m; 55

NHS 24
Runs an online and telephone-based information and advice service
£58.5m; 1 481

NHS Education for Scotland
Responsible for designing, commissioning and quality assuring education, training and lifelong learning for the NHS workforce
£399.4m; 1 151

NHS Health Scotland
Responsible for developing and implementing national programmes to improve population health
£21.8m; 313

NHS National Services Scotland (NSS)
Provides a range of services such as supplies, blood transfusion, information and statistics, and health protection
£262.9m; 3 422

National Waiting Times Centre
Runs the Golden Jubilee Hospital, receiving referrals from across Scotland to reduce waiting times, for example in orthopaedics, and regional and national heart and lung services, and the Beardmore Hotel and Conference Centre
£49.2m; 1 430

Scottish Ambulance Service
Provides emergency ambulance and non-emergency patient transport services
£216.4m; 4 160

State Hospitals Board for Scotland
Provides high security forensic and psychiatric care at Carstairs in Lanarkshire
£74.7m; 684

Source: Scottish Government, 2012e.

2.3.7 Independent (private and non-profit-making) sector

In addition to the NHS, there is a relatively small independent sector, regulated from 2000 until 2011 by the Scottish Commission for the Regulation Care (known as the Care Commission) and now by HIS. This comprises:

- 7 acute medical and surgical hospitals (306 beds) offering inpatient, outpatient and day-care services ranging from routine investigations to complex surgery;
- 10 mental health hospitals and clinics (342 beds and 50 day-case places), providing assessment, treatment and rehabilitation for children and young people with eating disorders, people with learning disabilities, people requiring intensive psychiatric care, and people with drug and alcohol problems;
- 15 voluntary hospices (286 beds and 160 day-case places) providing specialist palliative care on an inpatient, outpatient and day-care basis;
- 2 specialist clinics providing cosmetic and laser treatment (Care Commission, 2011).

With the exception of hospice care, this sector is funded mainly by VHI or paid directly by patients. Hospices have charitable status and do not charge for their services; they receive a substantial part of their funding from the NHS. The NHS also contracts to a very limited extent with the private sector for the provision of certain services to NHS patients. There has only been one Independent Treatment Centre in Scotland – the Scottish Regional Treatment Centre established in 2005 in Angus, treating patients from Grampian, Tayside and Fife; however, it became fully owned by the NHS in 2010.

As in England, the private and third sectors are important players in the care of older people. There are 522 care homes that provide nursing care, registered with and regulated by the Care Commission, which in 2011 became Social Work and Social Care Improvement Scotland (known as the Care Inspectorate), along with nearly 800 residential care homes.

2.3.8 Other organizations

The senior officers of NHS boards meet regularly and have easy access to ministers and officials in the Scottish Government. For this reason there has never been much support for a representative organization. For a few years there was a Scottish branch of the NHS Confederation, with most boards in

membership, but this was disbanded in 2006. Scotland does have a relationship with NHS Employers as the negotiating body on workforce and employment issues that continue to be handled at United Kingdom level.

The professional and staff organizations representing NHS staff, such as the British Medical Association, the Royal Colleges of Nursing and Midwives, the British Dental Association, UNITE and UNISON operate across the United Kingdom but have offices in Scotland headed by senior officials. In general their autonomy from London has increased significantly since devolution. Scotland has three medical royal colleges (the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow) responsible for promoting and maintaining standards through examinations, education, training and other activities, and for representing the views of their members to government and other organizations. As well as in Scotland, they have members working in other parts of the United Kingdom and overseas. With the Scottish branches or divisions of United Kingdom Colleges such as the Royal Colleges of Psychiatrists and Anaesthetists, they come together in the Academy of Medical Royal Colleges and Faculties in Scotland (the Scottish Academy), which promotes and coordinates the work of the colleges and faculties, and gives the medical profession a collective voice on clinical and professional issues.

Charities and the voluntary sector have always played a significant part in the health system and continue to do so, frequently working in close partnership with statutory bodies. They are involved to varying degrees in the delivery of services funded by the NHS and local authorities and by charitable donations; they represent users of services, and they lobby government on behalf of their members. Some are part of United Kingdom organizations, with varying degrees of autonomy, while others are separate Scottish organizations. On common issues relating to the third sector they are represented by a national intermediary body, Voluntary Health Scotland, with over 150 members and a similar number of associates.

2.4 Decentralization and centralization

Although funding for the NHS originates in the United Kingdom Treasury, Scotland is responsible for determining its own health policies and there is increasing divergence from England. There is a strong sense of corporate identity and cohesion. NHS boards are directly accountable to the Cabinet Secretary who in turn is accountable to the Scottish Parliament. The Cabinet

Secretary meets NHS chairs monthly, and the Chief Executive of the NHS meets board chief executives similarly. There is also a well-established system of performance management (described in section 2.5).

However, NHS boards have significant powers to determine the pattern of local care provision and to set local priorities. The overall purpose of each board is to ensure the efficient, effective and accountable governance of the local NHS system, and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes. Its functions comprise:

- **strategy development** – to develop a local health plan for its area, which addresses the health priorities and needs of its resident population, and within which all aspects of NHS activity, in relation to health improvement, acute services and primary care are specified;
- **resource allocation** – to address local priorities by deciding how the funds allocated to it are deployed locally to meet its strategic objectives;
- **implementation** of the local health plan and the local delivery plan;
- **performance management** of the local NHS system, including risk management (NHSGGC, 2012).

2.5 Planning

There is no formal national plan, although planning occurs at national, regional and local (board) levels. The Scottish Government health directorates provide the framework within which NHS boards operate and it specifies the key targets they must work to attain. Since 2007 these have been linked explicitly to the Scottish Government's overall National Performance Framework. Within this framework each board produces its own local health plan and local delivery plan, which are agreed with the directorates, and collaborates in regional and national planning in relation to supra-board issues. In addition, the directorates develop health policies and boards are expected to abide by national standards and guidance developed by the Scottish Government and by various other bodies.

2.5.1 National Performance Framework

Since 2007 the Scottish Government has adopted an outcomes-based National Performance Framework, replacing the proliferation of priorities that existed previously. Each part of this Framework is directed towards a single overarching

purpose: "to focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing economic sustainable growth" (Scottish Government, 2007e).

Five strategic objectives support delivery of the purpose (a Scotland that is wealthier and fairer; healthier; safer and stronger; smarter; and greener) and, in turn, these are supported by 16 national outcomes that describe in more detail what the Scottish Government wants to achieve over a 10-year period. Progress on these outcomes is measured through 50 national indicators and targets. A significant number of these outcomes and indicators relate to health.

An important part of the Performance Framework is the single outcome agreements (SOA) between the Scottish Government and each community planning partnership (CPP). Established under the Local Government in Scotland Act 2003, CPPs are intended to help public agencies to work together with the community to plan and deliver better public services. Led by local authorities, core partners are NHS boards, enterprise networks, police, fire and regional transport partnerships, and other public, voluntary, community and private sector organizations are also involved. SOAs are the means by which CPPs agree the strategic priorities for their local area and express them as outcomes to be delivered by the partners, individually and jointly, that contribute to the national outcomes. An official review of community planning and SOAs commenced in January 2012.

The NHS was in a strong position to embrace this new approach as a result of the delivery focus adopted in 2006. *Delivering for health* (Scottish Executive, 2005d) set out new arrangements for the management of performance in the NHS. A delivery group was established within the then Health Department to focus on key objectives, targets and measures. This system, described in the following sections, was aligned in 2007 to the National Performance Framework and the NHS was the first part of the public sector to report its performance through the Scotland Performs system and web site (Scottish Government, 2012g).

NHS boards are required to produce annually a three-year local delivery plan, which sets out agreed and quantified actions for achieving objectives and targets, known as HEAT targets, linked to the Scottish Government's overall purpose and outcomes, and since 2011 to delivery of its three 'quality ambitions', which are outlined in the next section (for latest guidance see Scottish Government, 2011g).

2.5.2 HEAT Targets

- **H**ealth improvement for the people of Scotland – improving life expectancy and HLE;
- **E**fficiency and governance improvements – continually improving the efficiency and effectiveness of the NHS;
- **A**ccess to services – recognizing patients' need for quicker and easier use of NHS services;
- **T**reatment appropriate to individuals – ensuring patients receive high-quality services that meet their needs.

Each objective has a number of targets and measures associated with it. Targets are measured nationally and reviewed annually with boards. Each board's local delivery plan contains an improvement trajectory and a risk management plan showing how it will achieve the targets. The Scottish Government agrees the plan with boards and this then forms an annual "performance contract".

HEAT targets are reviewed each year and a new suite is published each November. Once a HEAT target has been achieved it becomes a HEAT standard and boards are expected to maintain it but do not have to provide a delivery trajectory and risk narrative.

2.5.3 Quality ambitions

In 2010 the Scottish Government in partnership with the NHS established a new shared focus on pursuing excellence in health care through the development of a *healthcare quality strategy for NHSScotland* (Scottish Government, 2010m). This strategy provides the overarching context for prioritization of policy development and improvement. At its core are three quality ambitions:

- Mutually beneficial partnerships between patients, their families and those delivering health services, which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.
- There will be no avoidable injury or harm to people from health care they receive, and an appropriate, clean and safe environment will be provided for the delivery of health care services at all times.
- The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

Implementation of the *healthcare quality strategy* is overseen by a Quality Alliance Board chaired by the Director-General.

2.5.4 Health care policies

The Scottish Government health directorates determine the policies and priorities for the NHS and since devolution there has been greater divergence in policy from other parts of the United Kingdom and particularly England (see for example Jervis, 2008; Greer, 2005, 2010; Parry, 2003, 2004, for discussion of the factors influencing divergence and convergence in United Kingdom health policy). From time to time a new statement of these policies is published either at the Scottish Government's own initiative or in response to a report commissioned by the Scottish Government from an expert group. For example *Delivering for health* (Scottish Executive, 2005d) responded to such a report on how the NHS can plan and deliver better health care services in Scotland for the longer term: *A national framework for service change in the NHS in Scotland: building a health service fit for the future* (Scottish Executive, 2005b).

The two most recent statements of Scottish Government health policy are: *Better health, better care: action plan* (abbreviated in this report to *Better health, better care* (Scottish Government, 2007a)) and *The healthcare quality strategy for NHSScotland* (Scottish Government, 2010m). The Scottish Government also produces regular policy documents on specific areas, for example: *Better cancer care* (Scottish Government, 2008b), *Living and dying well* (Scottish Government, 2008g), *Better heart disease and stroke action plan* (Scottish Government, 2009b), *Scotland's national dementia strategy* (Scottish Government, 2010k). Guidance on specific matters is conveyed to NHS boards via "formal" chief executive letters (previously Health Department letters). Policies also continue to be focused on three long-standing clinical priorities: coronary heart disease (CHD) and stroke, cancer and mental health.

HIS is responsible for developing clinical standards, of which around 50 have been developed covering specific conditions such as cancer, heart disease and diabetes, and broader topics such as health care associated infection and anaesthesia. It also includes the Scottish Intercollegiate Guidelines Network (SIGN), which has been producing clinical guidelines since 1993, and the Scottish Medicines Consortium (also part of HIS), which assesses the clinical effectiveness, and cost–effectiveness of newly licensed medicines. In these areas, its role is similar to that of the National Institute for Health and Clinical Excellence (NICE) in England and Wales. NHS boards are expected to follow advice provided by either HIS or, where relevant, NICE.

2.5.5 Planning mechanisms

A considerable amount of planning activity occurs at national, regional and board levels. Nationally, a National Planning Forum, comprising representatives of the directorates and all boards, decides which planning issues need to be tackled on a supra-regional or national basis and commissions work in these areas. It links closely with the National Services Division of NSS. Its role is to commission services of a specialized nature (e.g. liver transplantation, cochlear implantation, hyperbaric medicine), manage specialized clinical networks (e.g. genital anomalies, acquired brain injury, very rare cancers), and run screening programmes (e.g. breast, bowel, cervical and diabetic retinopathy).

Since 2004 regional planning has been of increasing importance. Three regional planning groups (RPG) (North of Scotland, South East and Tayside, West of Scotland) work to develop a coordinated approach to service delivery, to facilitate commissioning and monitoring of services that extend beyond board boundaries, and to develop strategic workforce solutions. Each RPG has delegated authority from member boards to take decisions, by consensus, and to commit resources within an agreed financial framework (Scottish Executive, 2004e).

At the local level, in addition to the local delivery plans described above, each board produces a strategic plan, known as the local health plan looking three to five years ahead. Each plan, which is submitted to and agreed with the directorates, has four components: a health improvement plan, a health care plan, a financial and resources plan, and a change and development plan. It includes NHS action points from the joint health improvement plans drawn up as part of community planning for each local authority area in which the board operates.

2.6 Intersectorality

At national level, the structure of government and the National Performance Framework are designed to promote cross-sector working. Locally, NHS boards work closely with local authorities and others in planning services and in their delivery; this aspect of their work is being given increasing emphasis.

In 2007 the Scottish Government established a Ministerial Task Force on Health Inequalities including no fewer than seven ministers (responsible for public health, community safety, schools, children, communities and sport, enterprise, environment). Its report, *Equally well* (Scottish Government, 2008e),

set out a cross-sector strategy covering early years and young people, poverty and employment, physical environment and transport, alcohol, drugs and violence and health and well-being. This was followed up by an implementation plan (Scottish Government, 2008f) and policy frameworks on poverty and income inequality and on early years (Scottish Government, 2008a, 2008h); a review by the Task Force in 2010 confirmed the direction of the plan (Scottish Government, 2010f).

2.7 Regulation

As NHS boards are accountable to ministers, there is regular dialogue with officials. Annually (biennially from 2011), one of the ministers undertakes an accountability review with each NHS board during which s/he meets stakeholders such as staff and patient representatives and reviews performance against the board's local delivery plan, and the HEAT targets and quality ambitions. Reviews are open to the public who may also ask questions.

Since the 1990s the governance responsibilities of boards have been extended and made more explicit. In 1994 the first corporate governance guidance was issued to boards, accompanied by codes of conduct and accountability (Scottish Office, 1994). Four years later, guidance on clinical governance, defined as "corporate accountability for clinical performance", was issued (Scottish Office, 1998b); in 2002 the suite of governance documents was completed with guidance on staff governance, "corporate accountability for the fair and effective management of staff" (Scottish Executive, 2002a). Each of these circulars has statutory underpinning (Public Finance and Accountability (Scotland) Act 2000; Health Act 1999; NHS Reform (Scotland) Act 2004). Boards are required to establish a committee chaired by a non-executive director to take forward its duties in these areas: audit, clinical governance, staff governance (although there is some variation in the actual titles used) and their performance is monitored by Audit Scotland, HIS, and the Scottish Workforce and Staff Governance Committee on behalf of the Scottish Partnership Forum (see section 4.2.3).

The Cabinet Secretary regularly answers oral questions and responds to a substantial number of written questions from Members of the Scottish Parliament (MSPs). In addition ministers appear before the Health Committee and as appropriate other parliamentary committees to assist in their inquiries.

The Director-General and other officials also appear frequently before these committees as do the chairs and chief executives of NHS boards when issues arise relating to their boards.

Ministers have a general statutory power to direct an NHS board, as well as power to intervene in case of service failure. In practice these powers are unnecessary. Ministers have sufficient influence over the NHS in other ways to ensure that their wishes are enacted without recourse to legal action. The accountability of the NHS to ministers and Parliament makes traditional regulation inappropriate. However, in addition to the processes outlined above, the NHS is scrutinized by two bodies: Audit Scotland and HIS.

2.7.1 Audit Scotland

Audit Scotland is a statutory body set up in 2000 under the Public Finance and Accountability (Scotland) Act 2000. It undertakes work on behalf of the Auditor General for Scotland whose remit includes the Scottish Government, government agencies, and non-departmental and NHS bodies, and the Accounts Commission responsible for audit of local authorities and fire and police boards. The Auditor General is responsible for securing the audit of NHS boards either by Audit Scotland or by private accountancy firms, and for commissioning a programme of value for money studies. At any one time a number of such studies are under way on the performance of the NHS.

2.7.2 HIS

NHS Quality Improvement Scotland (NHS QIS) was created in 2003 with the aim of improving the quality of care delivered by the NHS. In April 2011 it became HIS as a result of the addition to its remit of the independent health care sector. It is responsible for:

- developing evidence-based advice, guidance and standards for effective clinical practice;
- driving and supporting improvements in health care practice (including coordinating the Scottish Patient Safety Programme);
- providing assurance about the quality and safety of care through scrutiny and performance reporting (HIS, 2011a).

On clinical matters, NHS boards are expected to act upon guidelines and standards produced mainly by HIS. Based on the standards it develops for care and treatment, HIS conducts reviews of performance in each board. Boards

complete a self-assessment questionnaire that is then validated by a visit undertaken by staff from other boards with experience of the service under review and members of the public. HIS then produces and publishes a local report on each visit and a national overview at the conclusion of each cycle. HIS does not have power to ensure compliance with its standards or to enforce its recommendations, but its reports have considerable authority and feed into the directorates' performance management process. HIS undertakes follow-up reviews as appropriate.

HIS also includes a Healthcare Environment Inspectorate, which is responsible for inspecting compliance with HIS's health care associated infection standards. It undertakes one announced and one unannounced inspection of each hospital every three years (HIS, 2011b). Since 2011 it also inspects services for older people in acute hospital care.

In 2011 responsibility for regulation of independent health care transferred from the Care Commission to HIS. HIS now registers and inspects services against national care standards and has power to take enforcement action against an independent provider, and ultimately to cancel its registration.

Regulation of most of the health care professions (by organizations such as the General Medical Council, the Nursing and Midwifery Council and the Health Professions Council)[1] and certain other regulatory roles, for example in relation to the licensing and safety of medicines by the Medicines and Healthcare products Regulatory Agency, are reserved at United Kingdom level. Details are provided in the HiT for England (Boyle, 2011).

Guidance is also produced by other organizations in Scotland such as Health Protection Scotland on the management of infectious and environmental hazards, and on reserved matters by United Kingdom organizations such as the Health and Safety Executive and the Human Fertilisation and Embryology Authority.

2.8 Patient empowerment

Over recent decades the extent and scope of patient and public involvement in the NHS has grown progressively. In terms of institutions, statutory "consumer" bodies were created for the first time in 1974. Local health councils (similar in constitution and powers to community health councils in England and Wales)

[1] Professions regulated prior to 1998 are reserved at United Kingdom level but professions regulated subsequently and any new regulatory body such as the General Pharmaceutical Council are devolved. Generally regulation of health care professions is taken forward on a UK basis led by the Department of Health with input as appropriate from the three devolved administrations.

were set up to monitor local health services, to advise and be consulted on health-related matters, especially service reorganizations and closures, and to assist patients in the complaints process. Their effectiveness varied widely and they were replaced in 2005 by a national Scottish Health Council (SHC) set up as part of NHS QIS (now HIS) but with a distinct identity. Its role is to promote patient focus and public involvement by supporting boards and by monitoring how they are carrying out their statutory duty to involve patients and the public in the planning and delivery of NHS services.

2.8.1 Patient information

Over the years patients have been able to access ever more information about particular conditions and procedures from leaflets and other written material, and increasingly from the internet. NHS boards have been encouraged to produce such material themselves, sometimes prepared in collaboration with patient groups, and to customize it to include advice about local services. However the quality of the information is variable, in content, presentation and accessibility, and there has often been unnecessary duplication.

Better health, better care (Scottish Government, 2007a) therefore committed the Scottish Government to working with the voluntary sector to establish a national health information and support service to provide a single online health information online resource which brings together quality local and national information from the NHS and other sectors, a national health information helpline, and a network of branded health information support centres embedded in local communities. This became operational in 2010 as NHSinform under the auspices of NHS 24.

Increasing amounts of information are also available to the public about the services provided by the NHS and how well they are performing. NHS boards meet in public and the reports presented to these meetings are available in paper format and on boards' web sites; boards publish annual reports and, since 2005, the Chief Executive of the NHS has also produced an annual report on overall performance (e.g. Scottish Government, 2011f). There is great detail on particular topics in the reports of organizations such as Audit Scotland and HIS, all of which are in the public domain, and on the web site of the ISD. In addition, the NHS is subject to freedom of information legislation (principally the Freedom of Information (Scotland) Act 2002).

2.8.2 Patient choice

Traditionally, patients have freedom to choose a GP practice, subject to the list being open and the GP being willing to accept them (for example, if they live outside the practice's catchment area). Patients can be treated at any NHS hospital provided their GP is willing to refer them. This remains the case and much more information is now provided to enable them to make a more informed choice. In other respects, however, patient choice is not regarded as a driver of quality improvement and efficiency. For example, it is not mentioned in the latest statement of Scottish Government policy. Under the Patient Rights (Scotland) Act 2011 patients have a right when the waiting time guarantee is breached to be treated elsewhere either in the NHS, including the Golden Jubilee Hospital, or in the independent sector, but this is regarded only as a means to avoid further suffering rather than to incentivize local providers to reduce waiting times. This should not be seen as suggesting a weaker commitment in Scotland to involving patients as partners in their care. Various initiatives are being taken to support patients and their carers, particularly those with long-term conditions, in managing their own care (see section 5.7).

2.8.3 Patient rights

Patient rights are enshrined in a complex system of legislation, conventions and case law. Over the years there have been a number of efforts to communicate these rights to patients. In 1991, simultaneously with England, Scotland produced the *Patients charter: a charter for health* (Scottish Office, 1991b). This was superseded over a decade later by a series of documents produced by Health Rights Information Scotland, a project undertaken by the Scottish Consumer Council (now Consumer Focus Scotland) with funding from the Scottish Government. *The NHS and you* is a general statement of what people can expect from the NHS and there are more detailed documents on confidentiality, access to health records, complaints and consent (HRIS, 2011). These are available online and NHS boards are also responsible for printing and distributing them locally.

The Patient Rights (Scotland) Act 2011 enacts the Scottish Government's commitment to improve patients' experience of using health services and to support them to become more involved in their health and health care. It places on ministers the duty to publish a charter of patient rights and responsibilities, bringing together in one place a summary of the rights and responsibilities that patients have when using NHS services; requires those who provide health care to take into account a set of statutory health care principles, such as patient focus,

quality care and treatment, patient participation, communication, complaints and waste; and puts the 12-week treatment guarantee for planned treatment on an inpatient or day-case basis on a statutory footing.

Guidance on the secondary legislation relating to the health care principles, the waiting time guarantee and the complaints procedure was issued in 2012 (Scottish Government, 2012f). The Patient Advice and Support Service (PASS), run by Citizens Advice Scotland (an independent charity) also became operational in 2012, providing help to patients and members of the public to understand their rights and responsibilities and to give feedback.

2.8.4 Complaints procedures

Guidance issued by the Scottish Government in 2005 sets out how the NHS should deal with comments, concerns and complaints (Scottish Executive 2005e). When something goes wrong and it has not been possible to resolve it informally with the staff directly concerned, a patient or carer can raise the matter formally with the staff concerned or an NHS complaints officer. The complaint is acknowledged within 3 working days and a full response is made within 20 working days (10 days for complaints relating to GPs, dental and optical practices and community pharmacies). If the complaint is not resolved the individual can take the matter to the Scottish Public Services Ombudsman. Complaints must be made within 6 months of the event or within 6 months of realizing there is a valid reason to complain but no longer than 12 months after the event (SHC, 2009).

From over 37 million contacts each year, the NHS deals with approximately 11 000 complaints a year. The majority of complaints relate to acute services (71%) and the types of issues raised most commonly are about staff (37%), treatment (29%) and waiting times (10%). Within staff complaints, the attitudes and behaviour of staff are the most common issues, followed by complaints about written and oral communication (ISD, 2011j). The most recent figures show that 27% of complaints were fully upheld, 33% were partially upheld and 38% were dismissed. About 900 complaints were referred to the Ombudsman (25% of the total), of which about 50% were upheld wholly or in part (SPSO, 2011).

Individuals can also take legal action if they feel they have suffered harm as a result of a breach of the duty of care that the NHS has to its patients. The number of claims rose during the 1990s but has been declining since 1999. There were almost 400 claims in 2009. The overall cost of settlements has grown steadily from around £5 million in 2000 to just under £25 million in

2009 but nonetheless is significantly lower per capita than in England. The average size of awards has also risen significantly (Scottish Government, 2011i). Concern has been expressed about the time taken to resolve claims, and the costs and adversarial nature of proceedings. This prompted the establishment of a No-Fault Compensation Review Group that reported in February 2011 (Scottish Government, 2011i). It concluded that the current system for dealing with claims does not meet the needs of patients and recommended the establishment of a no-fault compensation scheme for medical injury. In response the Scottish Government is committed to investigating how such a system might work in practice and is undertaking further analysis of its costs.

2.8.5 Public participation

NHS boards are required to involve people in designing, developing and delivering services they provide. These responsibilities were first made explicit in *Patient focus and public involvement* (Scottish Executive, 2001) and were reinforced in the NHS Reform (Scotland) Act 2004, which placed duties of public involvement and equal opportunities on NHS boards. This Act also established CHPs (see section 2.3), which were required to develop a Public Partnership Forum as one means to maintain an effective and formal dialogue with its local community.

The concept of a mutual NHS sees the Scottish people and NHS staff as partners, or co-owners, in the NHS (Scottish Government, 2007a). To give people a greater say in the services they use, the Scottish Government published updated guidance on informing, engaging and consulting people in developing health and community care services, which is supplemented by guidance produced by the SHC. Boards are also expected to follow the principles and practice for all public agencies set out in the *National standards for community engagement* (SCDC, 2005).

The current guidance, *Informing, engaging and consulting people in developing health and community services* (Scottish Government, 2010h) states that where a board is considering a service development or change, it is responsible for:

- informing potentially affected people, staff and communities of its proposal and the timetable for involving them;
- ensuring that the process is subject to an equality and diversity impact assessment;

- ensuring that any potentially adverse impacts of the proposed service change on, for example, the travel arrangements of patients, carers, visitors and staff, have been taken into account in the final proposal;
- providing evidence of the impact of this public involvement on the final agreed service change.

Where a proposed service change will have a major impact on a patient or carer group, members of equalities communities or on a geographical community, boards are expected to seek advice from the SHC on appropriate public involvement processes and from the health directorates on whether ministerial approval will be required. In some cases, ministers may decide to establish, normally before the board's formal consultation process, an independent scrutiny panel (ISP) to undertake an expert and impartial assessment of the safety, sustainability, evidence base and value for money of proposals and of the assumptions that underpin them, so as to assure the public that all of the relevant factors have been explored thoroughly. The panel's report, which is published, provides a comprehensive and accessible commentary on the evidence presented by the board but does not reach a view on a preferred option. To date, three ISPs have been convened.

The SHC has a key role in providing advice and support to boards and in quality assurance, ensuring that the process they are following complies with the guidance. For any proposed changes requiring ministerial approval, the board is required to submit a report from the SHC on the quality of the board's engagement and ministers reserve the right to ask a board to carry out a consultation process again in whole or in part if the SHC's assessment is negative. The SHC is also responsible for assessing how well boards are involving the public in planning and providing services. Initially this was based on a set of criteria it had developed, but in 2010 it issued a participation standard designed to measure how well boards focus on the patient, get the public involved and take responsibility for ensuring their staff involve the public (SHC, 2010).

From April 2011 boards have been asked to report their progress against the participation standard at their annual review meeting. After completing a self-assessment form, which boards base on discussion with their local stakeholders (members of the public, local community and patient groups, public partnership forums), SHC analysts have a dialogue with each board to reach agreement on what level has been achieved.

2.8.6 Patient experience

Over the years, NHS and GP practices have undertaken many patient surveys, and this has been encouraged by successive ministers. However, these surveys have been of variable quality; as they were commissioned locally, comparisons among hospitals and boards was difficult; and they tended to focus on patient satisfaction and thus provided little information to guide action to improve the quality of services.

For these reasons the Scottish Government launched in 2008 Better Together, Scotland's patient experience programme, designed to embed patient experience as an integral part of NHS business. Patient feedback is collected as part of the programme through a range of approaches, including surveys and qualitative techniques, focusing initially on patients receiving hospital care as inpatients, GP services and those with long-term conditions.

To date five surveys have been undertaken, one on GP services, one on GP and local NHS services and three on inpatient experience. In addition the programme has produced an experience measurement tool for use in hospitals and wards and has run training workshops on digital stories and an emotional touchpoints tool. A toolkit for the use of story was published in 2011 (Better Together, 2012).

3. Financing

Per capita public spending on health in Scotland is higher than in the rest of the United Kingdom (£2072 per year compared to £1926) but this differential has narrowed steadily in recent years. Since 2000 health spending has more than doubled in cash terms and increased by about 40% in real terms. It now accounts for 10% of GDP in Scotland and for 34% of the Scottish Government budget. In the current spending period (to 2015), health is the only sector with an increasing resource budget in cash terms. However, efficiency and productivity savings of at least 3% a year are needed to maintain financial balance in the face of inflationary, demographic and clinical pressures. In 2011/2012, three-quarters of the national health budget of £11.68 billion comprised core allocations to territorial and national boards, 12% was allocated for primary care contractor services, and the rest was earmarked for specific programmes. Allocation is based on a formula that reflects the relative needs of different geographical areas.

Around 83% of total health spending in the United Kingdom (separate Scottish data are not available) is publicly funded. The remainder comes from private VHI (which covers 8.5% of the population in Scotland); user charges for dental care and ophthalmic services (prescription charges were abolished in 2011); and direct payments for dental care, ophthalmic services and private treatment in independent or NHS facilities.

As there is no purchaser–provider separation, there are no contracts between boards and their operating divisions. Most primary care providers are independent contractors reimbursed for the services they provide to the NHS under the terms of their contracts. NHS boards directly employ, on a salaried basis, the staff working in hospitals and the community. They also manage, through CHPs, the contracts of independent contractors in primary care (GPs, dentists and community pharmacists).

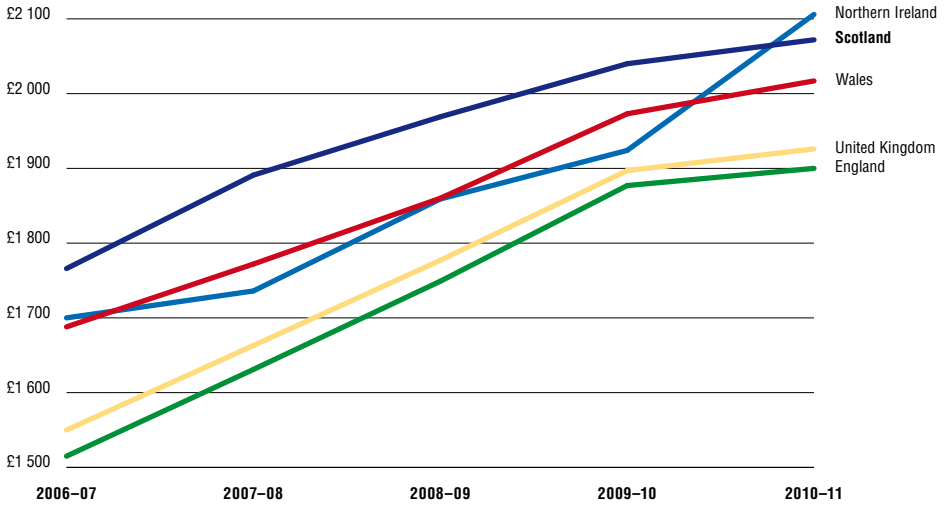
3.1 Health expenditure

Total health expenditure in Scotland, as in the rest of the United Kingdom, comprises publicly funded expenditure, VHI and out-of-pocket spending on treatment and products including over-the-counter medicines. There are no official figures for total health expenditure and this section therefore covers only publicly funded spending.

Expenditure per capita in Scotland is significantly higher than in the other United Kingdom countries. Inter-country comparisons are difficult because of differences in definitions. Fig. 3.1 uses Treasury data to compare spending per head in the United Kingdom, which was £2072 in Scotland in 2010/2011 compared with £1926 for the United Kingdom and £1900 in England. This differential has narrowed in recent years from 16.5% in 2006/2007 to 9% in 2010/2011 (HM Treasury, 2011).

Fig. 3.1

Health spending per capita in the United Kingdom 2006/2007–2010/2011



Source: HM Treasury, 2011.

From 2000 until 2009 spending on health increased substantially, more than doubling in nominal terms and increasing by almost 40% in real (inflation-adjusted) terms (Audit Scotland, 2009d). As a proportion of GDP it grew from 7% in 2000 to 10% in 2010/2011. Since then the rate of growth has fallen and the Scottish Government's plans for 2012, 2013 and 2014, announced in September

2011, will see annual nominal growth of between 1.2% and 1.9%. This will result in a real (inflation-adjusted) decline of 2.8% over this period (Scottish Government, 2011k).

The Scottish Government provided £11.68 billion for health in 2011/2012, which comprised 34% of its total budget. Of this sum, 76% comprises core allocations to territorial NHS boards and national health bodies (£8.6 billion in 2011/2012). The remainder, of which the largest element is for primary care contractor services (12%), is either spent directly by the Scottish Government or transferred to boards earmarked for specific programmes (see Table 3.1).

Table 3.1

Public health expenditure by programme, 2011/2012

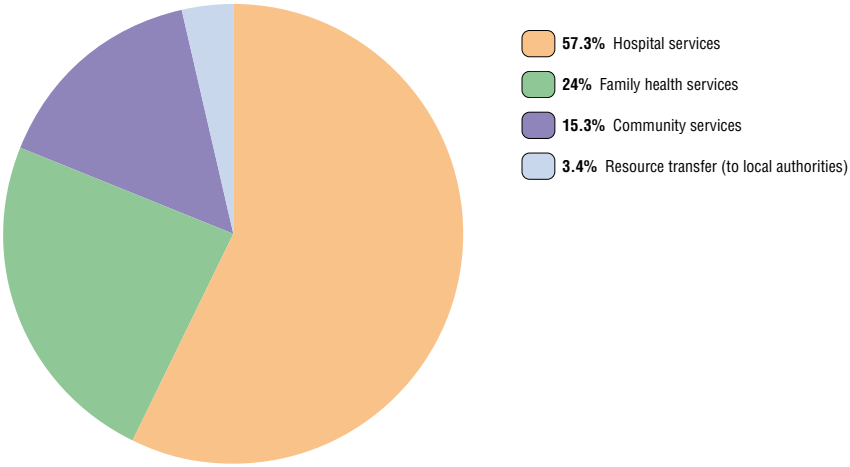
Programme	£m	%
Territorial NHS boards and national health bodies	8 645.1	76.0
Primary care contractors	13 88.0	12.2
Capital investment	488.2	4.3
Improving health and better public health	218.1	1.9
Nurse education and development	136.2	1.2
Impairments	100.0	0.9
eHealth	90.3	0.8
Research	68.6	0.6
Access support	101.3	0.9
Other services	132.9	1.2
Total	**11 682.7**	**100.0**

Source: Scottish Government, 2012h.

The spending in 2010/2011 of the boards that provide direct patient care is summarized in Fig. 3.2. Despite shifts to move more services into the community, hospital services still account for almost 60% of boards' spending. The largest item of expenditure is on staff, which accounted for 71.5% of the running costs of hospital and community services; 14.6% was spent on prescription drugs in all parts of the service (two-thirds in community pharmacies and one-third in hospital and community services) (ISD, 2011r). Just over 3% was transferred to local authorities in support of community care services; and 0.6% to the private sector (Audit Scotland, 2011c).

Fig. 3.2

Distribution of spending by 14 territorial NHS boards, Golden Jubilee Hospital and State Hospital



Source: ISD, 2011r.

Health is the only area of spending with an increasing resource budget (in cash terms) over the current spending period. However, this "protection" of the health budget is relative and efficiency and productivity savings of at least 3% a year are needed to maintain financial balance in the face of inflationary, demographic and clinical pressures. In 2010/2011 NHS boards delivered efficiency savings of £262 million, the third successive year in which the target had been exceeded. Since 2009 an Efficiency and Productivity Programme has focused on a number of cost-reduction areas (e.g. acute flow and capacity management, prescribing, procurement and shared services, and service redesign) and on high-volume, high-cost services (Scottish Government, 2011e).

3.2 Sources of revenue and financial flows

In 2008 some 83% of health care spending in the United Kingdom came from public sources (OECD, 2010). The remainder was funded privately through user charges, direct payments and private VHI. Separate figures are not available for Scotland; however as the penetration of VHI is lower than in the United Kingdom as a whole (see section 3.5), the proportion of care that is publicly funded is also greater.

3.2.1 Compulsory sources of finance

The NHS is financed mainly through general taxation (76.2%) with a further 18.4% coming from the NHS element of National Insurance Contributions (NICs), both of which are levied by the United Kingdom Government. The remainder comes from charges and receipts, including land sales and proceeds from income-generation schemes. NHS boards do not have the power to levy taxes; local taxes levied by local authorities (council tax and business rates), while important in relation to social work services, including home and residential care, do not fund health care.[1] NHS boards have limited income-generation powers, under the terms of the Health and Medicines Act 1988, to raise income for example through the lease of retail units on hospital premises, provision of amenity beds (see section 3.4.2 *Direct payments*) and charging for use of conference facilities.

3.3 Overview of the statutory financing system

3.3.1 Coverage

Since its inception, the aim of the NHS has been unchanged: to provide access to health care to all residents, irrespective of their ability to pay. Entitlement to health care under the NHS depends upon an individual being "ordinarily resident" in the United Kingdom. This means that not only residents of Scotland but also residents of the other United Kingdom countries have access to NHS services when in Scotland. Statutory regulations govern access to treatment for "overseas visitors". Generally they are entitled to free treatment in accident and emergency departments or walk-in centres in an emergency, but any subsequent inpatient or outpatient treatment must be paid for, for various specific services such as infectious diseases and for compulsory forms of psychiatric treatment. GPs are also required to provide free emergency treatment. Some categories of visitor are exempt from charges including nationals of states where there are reciprocal agreements, in particular members of the European Economic Area, covering treatment which in the opinion of a GP is medically necessary during a visit (Citizens Advice Bureau, 2012).

There is no defined list of benefits. Under the NHS (Scotland) Act 1978 Scottish ministers are required to provide or secure a comprehensive and integrated health service and the overarching principle since the inception of

[1] Local authorities meet the costs of free nursing care but this is mainly financed by a Scottish Government grant supplemented out of general local authority revenue.

the NHS has been that coverage should be comprehensive. In practice, this is not a promise to provide anything and everything that might be deemed to be a health service. The term "comprehensive" leaves some scope for discretion to be exercised by Scottish ministers and NHS boards to determine which services will be provided. For example, user charges are levied for certain services (see section 3.4); there are criteria that are used to determine entitlement to nursing care for older people and those with long-term conditions. Certain treatments are also not available under the NHS (e.g. some expensive cancer drugs, certain dental treatments, open-access preventive health screening).

Most of these decisions are taken by the Scottish Government and apply in all parts of Scotland. However, individual NHS boards also make choices about the type and quantity of services to be provided locally within their allocated budgets. This has led to some inter-area variation in the range of services provided, which at times is controversial, leading to accusations of "postcode rationing" and to fears that one of the fundamental tenets of a national service is being eroded. In particular, there has been controversy in relation to access to new medicines, especially expensive cancer drugs, which prompted the Labour government elected in 1997 to develop arrangements for providing evidence-based guidance, developed through the use of health technology assessment, to health organizations across the United Kingdom.

3.3.2. Collection

NHS funds are collected through general taxation and to a lesser extent NICs. Income tax, VAT, corporation tax and excise duties (on fuel, alcohol and tobacco) are levied by the United Kingdom Government and collected by HM Customs and Revenue. Taxes in the United Kingdom are generally not earmarked for particular purposes.

NICs (effectively another form of taxation) are compulsory contributions paid by employers, employees and self-employed people on earned income only (i.e. not on pensions, interest and dividends). They are intended to provide an entitlement to contributory benefits such as state pensions, and sickness and unemployment benefits. Although entitlement to NHS treatment is not based on having paid NICs, around 10% of NIC revenue is used to fund the NHS. This proportion has increased significantly as a result of the decision of the last Labour government to fund substantial increases in spending on the NHS through an increase in NICs, which could in effect be earmarked for the NHS.

3.3.3 Pooling and allocation of funds

Public spending is mainly provided by the United Kingdom Government, through HM Treasury, in the form of an overall block grant. In addition, funds are raised by local authorities by means of non-domestic rates; local authorities also have borrowing powers.

Changes to the block grant are generally determined by a formula, the Barnett formula (named after the Chief Secretary to the Treasury between 1974 and 1979), which is applied to all three devolved administrations. Under the formula, Scotland, Wales and Northern Ireland receive a population-based proportion of changes in planned spending on comparable services in England. Changes in each devolved administration's spending allocation are determined by the quantity of change in planned spending in departments in England of the United Kingdom Government, the extent to which the relevant English programme is comparable with the services carried out by each devolved administration, and each country's population proportion (HM Treasury, 2010).

In relation to health, the Scottish Government therefore receives its formula share of any increase in resources provided to the Department of Health in London. However, the allocation of public spending among the various services it controls is for the Scottish Government to decide, subject to the approval of the Scottish Parliament. To this end it has developed a Budget Process that operates on a two-year cycle and a biennial Spending Review. In Spending Review years the process is made up of three stages; in the other year, when there is generally little change in budget numbers, the process is truncated. It has been designed to encourage wide debate, in committees and in the full Parliament, about how the budget is spent.

The three stages of the process are:

- *Stage 1 – Annual Evaluation Report* (Spending Review years only), which is a long-term strategy document reporting on progress against targets from the previous Spending Review and setting out the Scottish Government's priorities for the next Review.
- *Stage 2 – Draft Budget,* which is published annually in the autumn and sets out the Scottish Government's detailed spending plans for the coming year. Individual parliamentary committees consider relevant parts.
- *Stage 3 – Budget Bill*. The Budget Bill, taking into account comments at Stage 2, is laid before Parliament in January and must complete all its stages (debate in Parliament; evidence session at the Finance Committee;

followed by a further debate in Parliament) by mid-February. Once enacted, the Bill provides the statutory authority for expenditure by the Scottish Government (Scottish Government, 2010c).

It is then the responsibility of the health directorates to advise ministers on how the overall budget should be spent.

In 1999, the then Health Department conducted a major review of the method used to allocate funding among the territorial NHS boards. At that time, the allocation formula was based on a system that had been established in the late 1970s, and relied largely on subjective judgements about how best to meet the relative needs of the populations in different board areas. The aim was to move to an allocation system that would rest on a clearer evidence base about the relative needs of different populations and led to major changes in the methods used to allocate funds.

The new Arbuthnott formula (named after the review's Chair), introduced in 2001–2002, was population based but with extra weight given to certain factors, such as the number of older people in particular areas, levels of deprivation, and additional costs of providing services in rural and remote areas (known as weighted capitation). It was designed to provide greater resources to areas of greater need. About 75% of the total NHS budget was distributed through this formula. This included all hospital and community health services, and GP prescribing (Scottish Executive, 2000b).

In 2005 the Health Department set up an NHSScotland Resource Allocation Committee (NRAC) to improve and refine the Arbuthnott formula, and consider the scope for extending the formula to cover all areas of primary care. The NRAC also considered the case for adopting a further adjustment to allow for unmet needs that are not properly reflected in utilization data. The NRAC completed its work in 2007 and a refined formula, based on its recommendations, has been used for the allocations to NHS boards since 2009/2010 (Scottish Government, 2007d). The current formula operates in a similar manner to Arbuthnott but is built up from smaller geographical areas to improve the accuracy of predicting needs and allow it to be used for planning purposes at CHP level; it takes better account of the higher relative needs of the elderly and the very young, and the impact on resources of lengthening life expectancy. It also more accurately reflects the increased need for health care services in areas of deprivation and poor underlying health, and compensates for the under-use of health services in such areas.

In total, the NRAC changes would redistribute £81.9 million among boards, or 1.2% of the overall budget. However, successive governments have guaranteed that no board should receive an actual reduction in its funding and progress towards "parity" has been achieved through differential distribution of additional funding. NRAC also reviewed allocation formulae created for primary care ophthalmic, dental and pharmaceutical services in the NHS, and recommended that these be developed for implementation when new contracts and policies covering these services are fully implemented.

3.4 Out-of-pocket payments

Most NHS health care in Scotland is free at the point of use. However, some services are subject to user charges in the form of co-payments or are not covered by the NHS and patients therefore have to pay themselves (direct payments).

3.4.1 User charges

NHS prescriptions

User charges for prescriptions were first introduced in 1952 and applied since then, apart from a brief period between 1965 and 1968, until they were discontinued in 2011. The Scottish Government announced its intention to phase out prescription charges in 2007, reducing them in stages until they were removed altogether in April 2011.

NHS dental care

User charges have always applied in relation to NHS general dental care provided by independent contractors and continue to do so (emergency dental services are provided free of charge by NHS boards directly). Dental examinations are free as is treatment for various groups such as children, young people in full-time education, people on income support or various other benefits or on low incomes, and women who are pregnant or who have given birth in the past 12 months. Otherwise patients pay up to 80% of the cost of treatment, calculated on an item of service basis, up to a maximum of £384 per course of treatment (Scottish Government, 2011b).

NHS ophthalmic care

Universal ophthalmic services are not available under the NHS. Charges were introduced for glasses in 1952 and in 1988 free eye tests were ended except for certain groups. In 2006 free – and more comprehensive – eye tests were re-introduced for everyone.

Other user charges

Additional funds are raised by charging inpatients in some hospitals for bedside telephones and television, and through hospital car parking charges. However, from 2009 car parking charges were abolished in all but three hospitals built under the private finance initiative (PFI; see section 4.1.1 *Capital stock and investment,* sub-section on *Investment funding*) where these are part of the contract with the service provider.

3.4.2 Direct payments

Direct payments cover private treatment in NHS facilities and over-the-counter medicines.

Private treatment in NHS hospitals

In some hospitals patients can pay for what is called an amenity bed – accommodation in a single room or side ward – made available at a charge when not needed by any patient on medical grounds. There is also statutory provision for private patients to be treated within NHS hospitals. In 2010/2011 income of £5 million was generated in this way and 0.12% of hospital stays were recorded as "amenity" or "paying" for part or all of the stay (ISD, 2011b).

Dental care

Most dentists offer services to both NHS and private patients. In recent years disputes between dentists and government over the level of charges for NHS dental treatment prompted some dentists to withdraw entirely from NHS work and others reduced the amount of NHS work they undertake. In response the Scottish Government has significantly increased recruitment to dental schools and encouraged boards to employ salaried dentists, including some from overseas. However, private dental insurance has expanded rapidly, and the total private dental market in the United Kingdom (separate figures are not available for Scotland) was estimated in 2008 to be worth around £3 billion per year, roughly equivalent to the cost of NHS provision (House of Commons, 2008).

Ophthalmic care

Most ophthalmic services are provided on a commercial basis by private opticians. Children, young people in full-time education, people aged 60 years and over, and people on income support and certain other benefits or on low incomes are also entitled to assistance with the cost of their glasses and contact lenses through an optical voucher system.

3.5 VHI

The contribution of VHI (as measured by premiums) to total health care expenditure is small relative to that of public expenditure, accounting for just 2.9% in the United Kingdom in 2008 (Boyle, 2011). Separate figures are not available for Scotland but, as the proportion of the population covered by VHI and self-insured medical expenses schemes is lower than in the United Kingdom as whole (8.5% in Scotland vs 12% in the United Kingdom), it is likely to be lower (Laing and Buisson, 2011).

Most expenditure on private acute hospital care in the United Kingdom is funded through VHI (61% in 2008), with self-payers accounting for only 14% of the total. NHS expenditure accounted for another 23.1% and the rest is mainly from non-United Kingdom patients. In Scotland the NHS spent £65 million in 2010/2011 on purchasing services from the private sector (0.6% of total NHS spending) (Audit Scotland, 2011c).

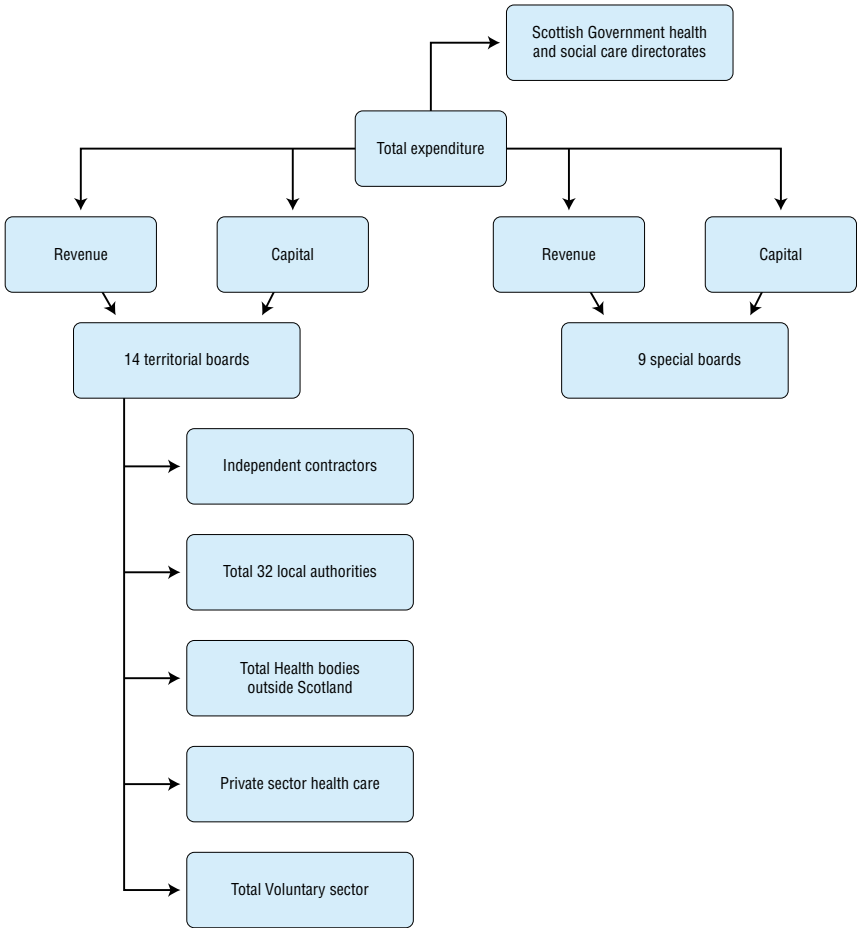
3.6 Payment mechanisms

3.6.1 Paying for health services

Fig. 3.3 displays how the resources provided by the Scottish Government for health via the block grant from HM Treasury flow through the system. Since the abolition of the internal market in 2004, there is no purchaser–provider separation and thus formal contracting for clinical services in Scotland has become redundant. An integrated model now operates with no separation between the commissioning or purchasing role and the provision of hospital and community services. In addition to the resources spent directly by boards themselves or by their operating divisions and CHPs on hospital and community services, boards reimburse primary care contractors for the services they provide to the NHS, pay for services provided by the independent sector

(private and non-profit-making) and by the NHS in other parts of the United Kingdom, and transfer resources to local authorities to assist in the funding of community care.

Fig. 3.3
NHS financial flows



Source: Adapted from Audit Scotland, 2011c.

Although there is no contracting within boards, work has continued as part of efficiency and productivity initiatives to improve the costing of individual services. A Scottish National Tariff Project was launched in 2005 to develop a list of national average estimated Healthcare Resource Group (HRG – standard groupings of clinically similar treatments that use common levels of health care resources) costs to support boards in agreeing cross-boundary inpatient flows for acute inpatients and day cases, to encourage benchmarking among boards and as a tool for identifying efficiency savings (ISD, 2011s).

3.6.2 Paying health workers

The contractual arrangements for payments to almost all personnel in the NHS are negotiated on a United Kingdom basis with only limited scope for variation in each of the four countries. Since 2004 NHS Employers – part of the NHS Confederation – has taken over from the Department of Health responsibility for negotiations about pay and conditions. Further detail about these arrangements is contained in the *United Kingdom (England) HiT* (Boyle, 2011).

Over the last decade a far-reaching programme of pay modernization has been introduced for all NHS staff. In 2004 agreement was reached on a new pay system – known as *Agenda for Change* – for all NHS staff except senior managers and those covered by the Doctors and Dentists Pay Review Body. It was implemented across the United Kingdom over the following four to five years (Scottish Executive, 2004a). In parallel, new United Kingdom contracts with very limited cross-border variation were introduced for consultants and GPs in 2004 (Scottish Executive, 2004d, 2004g), and a separate (but broadly similar) Scottish contract for community pharmacists in 2006 (Scottish Executive, 2006e). The payment system for dentists, for whom a new contract was introduced in England and Wales in 2006, is significantly different (DDRB, 2012). Since 1999 the pay and conditions of senior managers (around 1255 posts) have been subject to ministerial direction (Scottish Executive, 2006f).

4. Physical and human resources

The NHS estate comprises 4.6 million square metres of building space, 65% of which is accounted for by acute hospitals. In recent years there have been substantial programmes to dispose of surplus property and to build new facilities. Most NHS investment has been funded through public sector capital but since the 1990s schemes have been developed to introduce private finance (which accounted for just over one-third of capital spending in 2010/2011). Over the last 30 years there has been a substantial change in the infrastructure of the NHS as the number of hospitals and hospital beds has fallen steadily as a result of changes in clinical practice (such as the use of day surgery) and the development of services in the community. There has also been increasing investment in IM&T – an area in which Scotland has a high reputation in the United Kingdom and internationally – with a strong focus in recent years on eHealth (patient-related systems). The size of the NHS workforce has grown by 14% since 2002, reflecting the substantial increase in funding. The NHS has been in the forefront of developing partnership working with staff, underpinned by a statutory duty of staff governance and a Staff Governance Standard.

4.1 Physical resources

4.1.1 Capital stock and investment

Current capital stock

The NHS asset base is valued at approximately £5 billion, of which 80% is associated with land and buildings and the rest with fixed assets such as vehicles, medical equipment and IM&T (Audit Scotland, 2009a). The estate comprises over 4.6 million square metres of building floor area spread over 1000 buildings ranging in size from 40 to 200 000 square metres. Detailed

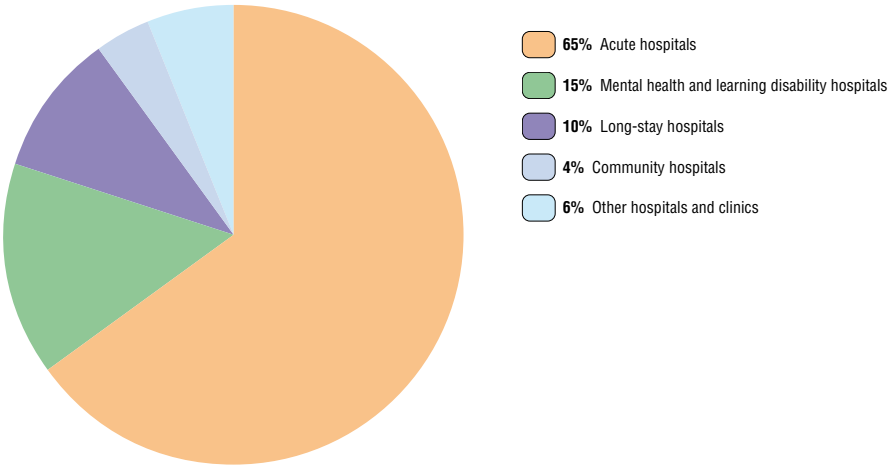
and consistent information on the 252 hospitals/buildings of the NHS estate was published for the first time in 2012 (Scottish Government, 2012i). Fig. 4.1 summarizes the estate's key characteristics.

Recently there have been two major developments regarding the NHS estate. First, there has been a substantial programme of disposal of surplus property, including the sale of land on which mental health and learning disability hospitals were located prior to their closure, as part of the process of developing services in the community. Second, after decades of neglect and underinvestment, there has been a massive building programme of new hospitals and health centres. In 1999, the Scottish Executive embarked upon the largest programme of hospital building in the history of the NHS in Scotland, amounting to £0.5 billion over the following eight years, including three major new hospitals in the Central Belt (Scottish Executive, 2005c). This has been continued by the SNP government since 2007, which has prioritized infrastructure investment both as a lever of economic recovery and to modernize public services.

Fig. 4.1

Analysis of NHS estate (in %)

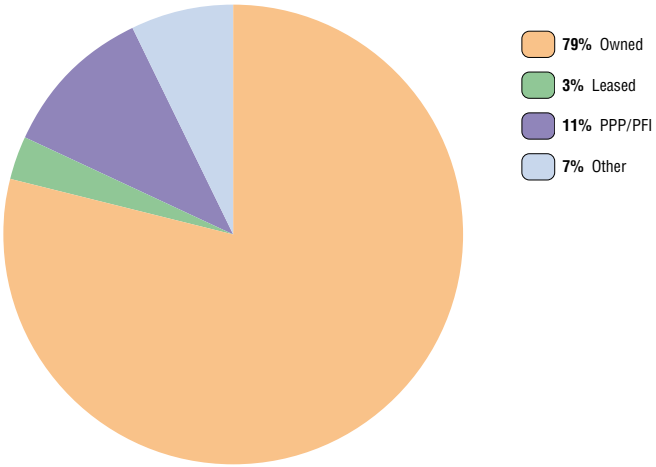
Building area



Source: Scottish Government, 2012i.

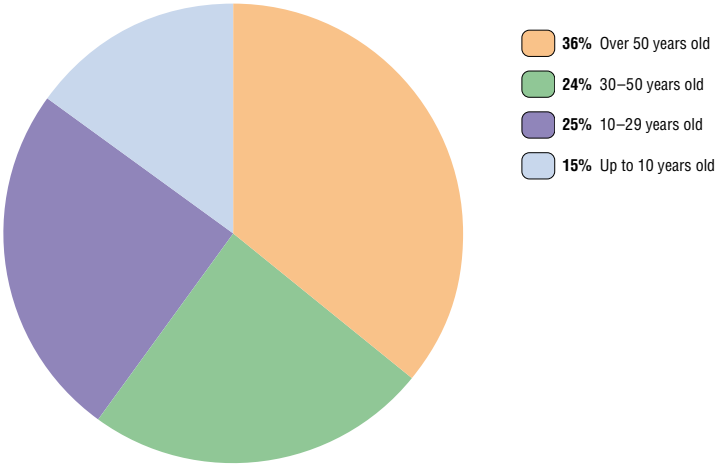
Fig. 4.1
continued

Property tenure



Source: Scottish Government, 2012i.

Age profile



Source: Scottish Government, 2012i.

Investment funding

Until the 1990s all capital investment was funded through allocations of public funds to the NHS. However with the introduction of the PFI/PPP and, more recently, non-profit distributing funding there has been more than one way in which new capital investment is funded, although ultimately government remains responsible for providing the funds in the long term to support any investment in new capital stock. In 2010/2011 these alternative mechanisms of funding accounted for 36% of capital spending (calculated on the basis of the value of the assets added to boards' balance sheets) (Scottish Government, 2011o).

As part of the annual spending round, the NHS is allocated a capital budget (£488.2 million in 2011/2012), part of which is distributed to boards by formula, and the rest allocated to specific large projects whose value is in excess of board delegated limits.

From 2011/2012 the same – NRAC – formula (see section 3.3.3 *Pooling and allocation of funds*) has been utilized to allocate the former element (roughly £90 million or 18% of the total) to NHS boards (Scottish Government, 2010b). The rest has been allocated to specific projects, of which the largest is the New South Glasgow Hospitals Project (£842 million).

In the 1990s the Conservative government attempted to introduce private finance to the health sector to fund major projects. This policy was maintained by the Labour government, which required the NHS to test the value for money of a PFI option (where the private sector agrees to finance, design, build a hospital and operate non-clinical services under a contract, often lasting 20–30 years, and the private finance is repaid through "unitary charges" out of current spending) against the use of public sector capital.

Although PFI enabled more investment than would have been possible by the public sector alone, it has proved controversial. Critics argue that as well as introducing private management into the running of non-clinical aspects of the NHS, payments were high over the life of the contract and the private sector was able to make large "windfall" profits, including through refinancing existing contracts (e.g. BMA, 2007; see also the summary of the advantages and disadvantages of different means of funding capital projects in Audit Scotland, 2011b).

The SNP government therefore announced in 2008 a new scheme called the Non-Profit Distributing Model to deliver revenue-financed investment. This seeks to transfer risk and exert private sector discipline both during the

construction phase of a project and throughout its lifetime, but with smaller profits to the private sector and reduced financing costs to the public sector in comparison with past PFI projects (Scottish Futures Trust, 2011).

In 2011/2012 there were 29 PPP/PFI/non-profit distributing projects in the health sector for which the estimated unitary charges to the private sector were £198 million (SPICe, 2011a). The two largest PPP/PFI projects are the Royal Infirmary of Edinburgh (completed in 2003 with over 900 beds) and Forth Valley Royal Hospital (completed in 2011, with 860 beds/day-care spaces). Current projects with a capital value of about £750 million are being funded in this way, of which a third is accounted for by two large projects in Edinburgh and the rest includes hospitals, health centres and mental health facilities. Almost half of these, mainly smaller projects, are being financed through the "hub initiative" led by an arm's-length body, the Scottish Futures Trust, which has established five hub territories across Scotland in which public sector organizations will work in partnership with each other and a private sector delivery partner.

NHS boards are responsible for initiating local capital schemes in accordance with guidance provided by the Scottish Government health directorates in the *Scottish capital investment manual* (Scottish Government, 2009d). Depending on the size of the project, they are required to produce different levels of documentation. For non-IM&T projects under £5 million (£10 million for the two largest boards), territorial boards approve their own business cases. Above these delegated limits, they have to be submitted to the health directorates' Capital Investment Group for approval.

Traditionally, GP partners have owned their premises and were reimbursed by the NHS for the costs involved via cost rent (reimbursement of the actual costs involved) or notional rent (based on the value of the premises). This is still the most common arrangement for established practices. The remainder are built and owned by boards with GPs paying rent and service charges. Increasingly GPs, especially younger ones, look to boards to provide premises, and this has been attractive to boards as a means of encouraging grouping of practices into larger purpose-built premises that can be shared with community services (BMA, 2006). However, in recent years limits on the funding available for investment in GP premises have given rise to pressure from GPs for this to be accorded higher priority (BMA, 2010).

4.1.2 Infrastructure

Over the last 30 years there has been a substantial change in the infrastructure of the NHS as the number of hospitals and hospital beds has progressively fallen and substantial programmes of replacement and upgrading of the capital stock have been completed.

The number of hospitals has fallen as a result of two developments (Woods & Carter, 2003). First, acute medical and surgical care has been withdrawn progressively from smaller hospitals, particularly in urban areas, reflecting quality, safety and human resource considerations, as well as the costs of maintaining ageing buildings, most of which were ill-suited for contemporary care. Second, long-stay hospitals for people with mental illness and with learning disabilities have been closed as services are provided in the community.

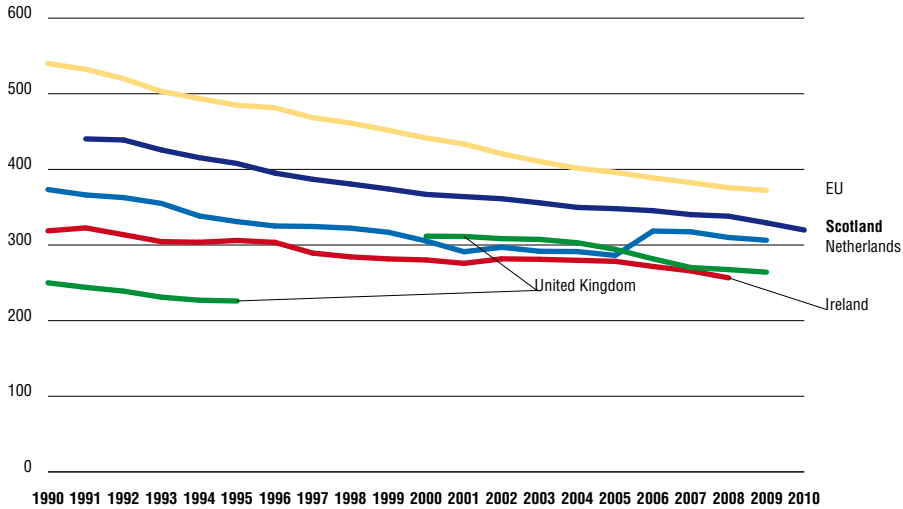
In parallel there has been a steady decline in the number of beds of all types in Scottish hospitals, as elsewhere in the United Kingdom and throughout Europe. The bulk of this fall is due to fewer beds for people with mental health problems and learning disabilities, and for frail older people. Between 1980 and 2000 the number of beds for people with mental health problems more than halved (17 168 to 7760) and for people with learning difficulties by more than two-thirds (7139 to 1907) and these trends have continued (Woods & Carter, 2003; Scottish Government, 2012b).

There have also been reductions in the number of acute hospital beds (Fig. 4.2). The number fell significantly in the 1980s and 1990s and this trend has continued since 2000, but at a slower rate, reflecting growth in day surgery and in ambulatory diagnostic and treatment services, and improved rehabilitation and discharge processes. In 2010, using EU definitions of acute beds, there were 320 such beds per 100 000 population in Scotland in comparison with 440 in 1991. Cross-country comparisons are difficult because of differences in definition, but Fig. 4.2 seeks to compare the position in Scotland with the United Kingdom overall and selected other countries in Europe. This shows that Scotland has significantly more beds per population than the United Kingdom but that nonetheless it lies below the EU average.

Other indicators tell the same story. As Fig. 4.3 shows, average length of stay in acute hospitals fell from 6.4 days in 1998 to 5.5 days in 2010 (ISD, 2011b). This is now lower than in the United Kingdom as whole (7.3 days). Bed occupancy rates have remained relatively stable, increasing from 78.6% in 1998 to 80.5% in 2010.

Fig. 4.2

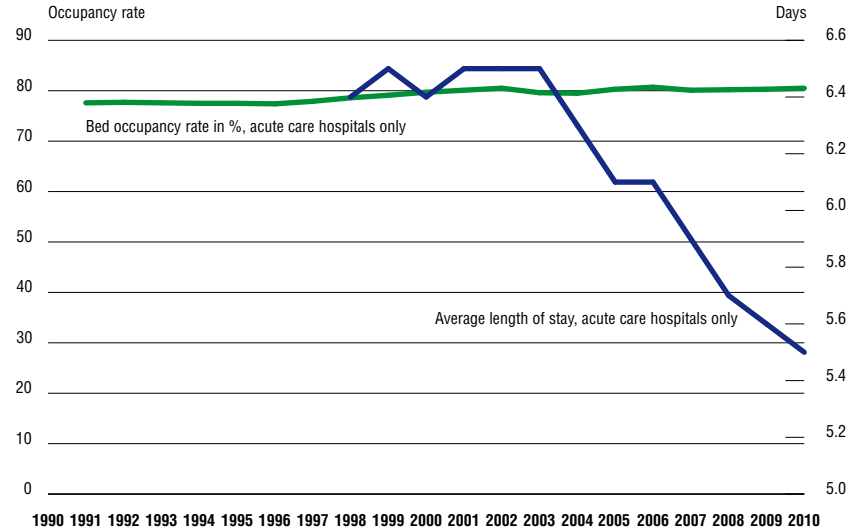
Acute care hospital beds per 100 000 in selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe, various years; Scottish data from ISD, 2012a.

Fig. 4.3

Operating indicators



Source: ISD, 2012a (for 2001/2002 to 2011/2012).

4.1.3 Information technology

Scotland has a long-established reputation, in the United Kingdom and internationally, for health service information. The ISD leads this effort, combining high-quality data, consistency, national coverage and the ability to link data to allow patient-based analysis and follow-up. However, until about a decade ago, the development of information technology (IT) systems was piecemeal, with organizations developing their own solutions and using a wide range of IT systems and providers. Spending on IT was relatively low and there was little system-wide thinking and a plethora of stand-alone systems. There were some exceptions that pointed to the way forward. For example, a primary care system, the General Practice Administration System for Scotland (GPASS), was widely but not universally adopted – in use at 85% of practices.

Partnership for care (Scottish Executive, 2003) heralded a change in emphasis, highlighting the importance of IM&T and the need to increase investment. The following year, the Health Department published an IM&T Strategy with a stronger focus on clinical applications (Scottish Executive, 2004c). However, spending on IT (estimated to be £65 million current and £35 million capital in 2006/2007) remained well short of the recommended level (3–4% of total health spend) (Audit Scotland, 2006).

Delivering for health (Scottish Executive, 2005b) placed "increased sharing of information, with unified databases, effective communication links and standardized protocols" at the heart of the drive to promote integration of services, and argued that "a comprehensive health information system built around an Electronic Health Record is vital to achieve the shift away from reactive, crisis-management, acute-oriented care towards anticipatory, preventative and continuous care". It also signalled a significant cultural shift towards a more corporate approach to IM&T, including curtailing boards' freedom to procure and implement systems locally and emphasizing the need for increased clinical buy-in.

Increasingly attention focused on patient-related systems (eHealth) but there was continuing development of back-room support systems in areas such as finance, human resources and supplies. The first eHealth strategy covered the period 2008–2011 (Scottish Government, 2008d). Its priorities were closely aligned with the key health service business challenges of delivering the 18 weeks "referral to treatment" target, mental health care, treating long-term conditions, integration across patient journeys, and improving capability and capacity. It had two main strands: a number of national systems and collaborative working among groups of boards.

Central to all these developments, and a key patient safety measure in its own right, is universal use of the unique patient identifier: the Community Health Index (CHI) number. To support this ambition, a national CHI programme was established in 2005 and, over the five years of the programme, significant improvements were achieved with the compliance target of 97% of clinical communications being exceeded.

Other national systems include:

- the national eReferral programme, using the Scottish Care Information (SCI) Gateway;
- the Picture Archiving and Communication System (PACS), supporting the seamless acquisition, storage, retrieval and display of digital patient images;
- the national Emergency Care Summary (ECS) to support unscheduled care;
- a new GP IT system replacing GPASS;
- Electronic Transfer of Prescriptions (ETP) between GP practices, community pharmacies, and Practitioner Services Division (responsible for reimbursement), which was introduced in 2008 – the first live national system to support ETP in the United Kingdom;
- the Scottish Centre for Telehealth and Telecare (established in 2003), which has been brought within the organization and governance framework of NHS 24, representing significant progress in telehealth and telecare.

Alongside these national systems, boards are increasingly working collaboratively to develop systems. For example:

- a consortium of five boards has chosen to use the TrakCare Patient Management System (PMS) system to improve clinical and administrative management of patient information, thus freeing up clinical time for patient care;
- NHS boards are working in three regional consortia, each developing different aspects of the Clinical Portal programme, to give clinicians improved access to patient information in support of direct patient care.

In support of these developments, a national technical architecture has been assembled and the Scottish Government has been working with boards to promote safe, effective and appropriate use of information through publication of an information assurance strategy and core guidance.

A second eHealth strategy, covering six years, was published in 2011 (Scottish Government, 2011p). Its aims, focused on realization of the three quality ambitions in the quality strategy, are to use information and technology in a coordinated way to maximize efficient working practices, support people to communicate with the NHS and manage their own health, contribute to care integration, and to support people with long-term conditions and improve the safety of people taking medicines and their effective use.

4.2 Human resources

4.2.1 Health workforce trends

In 2011 the NHS workforce in Scotland comprised 161 369 people, 6.5% of the working population. Of these, 154 541 (131 340 whole-time equivalent (WTE)) were employees of the NHS and the rest independent contractors (general medical and general dental practitioners providing services to the NHS). Staff costs accounted for over 70% of NHS expenditure. Over the last decade there has been significant growth in the size of the NHS workforce, reflecting the substantial increase in funding (Table 4.1). The total number of people employed by the NHS increased by 14% between 2002 and 2011.

Women account for over 75% of the workforce (compared with 50% for the Scottish workforce as a whole). In part this explains why the proportion employed on part-time contracts is also greater (40% in comparison with 25% overall). This makes it important when examining workforce trends to look at WTE numbers where these are available.

Doctors

In 2011 the total number of doctors working in the NHS was 17 383, an increase of 24% since 2002. Doctors comprise 11% of the total workforce. Of the doctors, 4937 (28%) were GPs, the rest (12 466) working in hospitals and community services and public health (11 237 WTE).

Table 4.1

Health workers in Scotland, selected years (headcount)

Profession	2002	2005	2011
All NHSScotland staff (including GPs and general dental practitioners)	141 130	151 956	161 369
All NHSScotland staff (excluding GPs and general dental practitioners)	135 479	145 961	154 541
Medical (hospital, community and public health services)	9 608	10 212	12 446
General medical practitioners	4 360	4 548	4 937
Dental (hospital, community and public health services)	645	657	892
General dental services	2 078	2 267	3 048
Nursing and midwifery	62 767	66 203	65 448
Allied health professionals	9 191	10 306	11 304
Health care science	–	–	6 044
Emergency services	2 981	3 369	3 772
Administrative services	24 450	28 320	28 859
Support services	16 811	17 824	18 767

Source: ISD, NHSScotland Workforce Data (selected years, main staff groups only listed).
Note: Changes in definition of staff groups make it difficult to present comparable data prior to 2002. Nursing and midwifery: includes all Agenda for Change bands, that is, qualified and unqualified staff.

The WHO Health for All database provides comparative data for European countries, including the United Kingdom (calculated differently, excluding double counting where an individual works in more than one part of the NHS). On this basis, Scotland in 2010 had 309 doctors per 100 000 population, rather more than in the United Kingdom overall (277) and closer to the EU average of 330 (2009). Fig. 4.4 compares the position in Scotland with selected European countries.

The number of GPs increased by 13% between 2002 and 2011. Based on the figures in Table 4.1, there were 94 GPs per 100 000 population in 2011 (more than in the other countries of the United Kingdom – using different definitions ONS reported 80 per 100 000 in Scotland in 2009 compared with 70 in England and 65 in Wales and Northern Ireland) (ONS, 2010). WTE data are not collected but a figure of 3700 was estimated in 2009 compared with a headcount of 4942 (ISD, 2009).

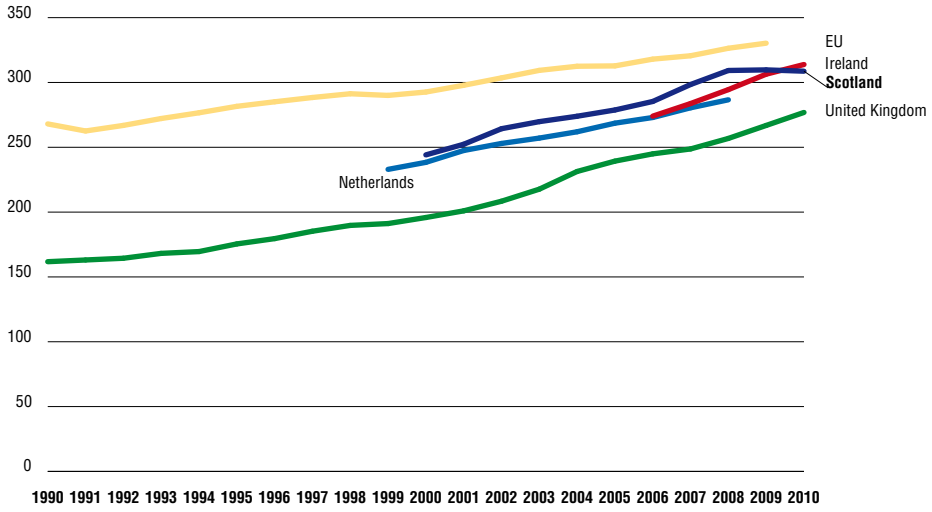
Nurses and midwives

Nurses and midwives (qualified and unqualified staff) constitute 41% of the NHS workforce and are thus by far the largest group of health workers. In 2011 there were 65 448 (56 309 WTE) an increase of 4.3% since 2002.

The WHO Health for All database includes only qualified staff (Agenda for Change bands 5–9). On this basis, Scotland has 947 nurses and midwives per 100 000 population, above the United Kingdom average (935) and significantly more than in England (810 in 2009) (Boyle, 2011). These figures need to be treated with great caution as, although other databases such as ONS (ONS, 2010) also record significantly more nurses per head in Scotland, they suggest a rather larger difference (and, given the proportion of United Kingdom nurses working in England, one would expect the United Kingdom average to be much closer to the English figure). Similar qualification is needed in interpreting the comparative data in Fig. 4.5, which show Scotland above the EU average.

Fig. 4.4

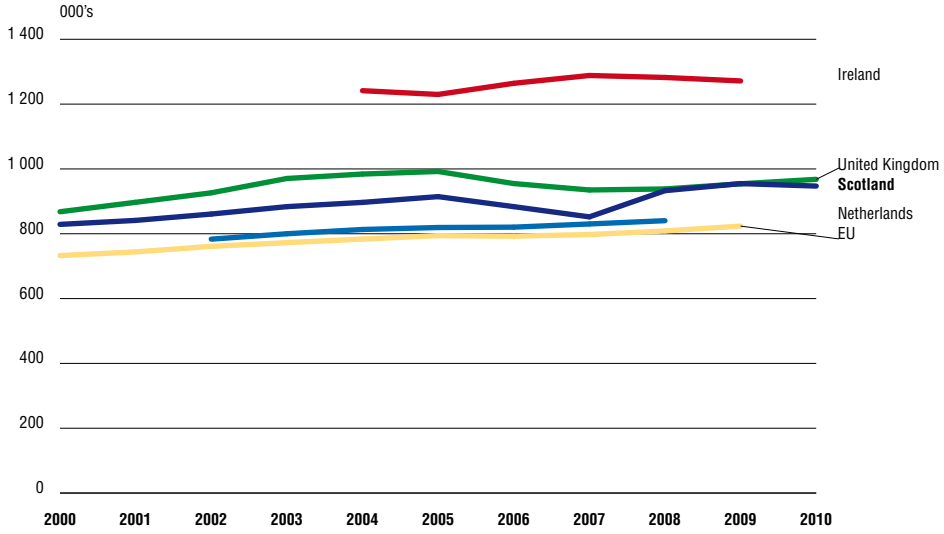
Physicians per 100 000 population, selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe, various years; Scottish data from ISD (email).

Fig. 4.5

Nurses per 100 000 population, selected countries, 2000 to latest available year

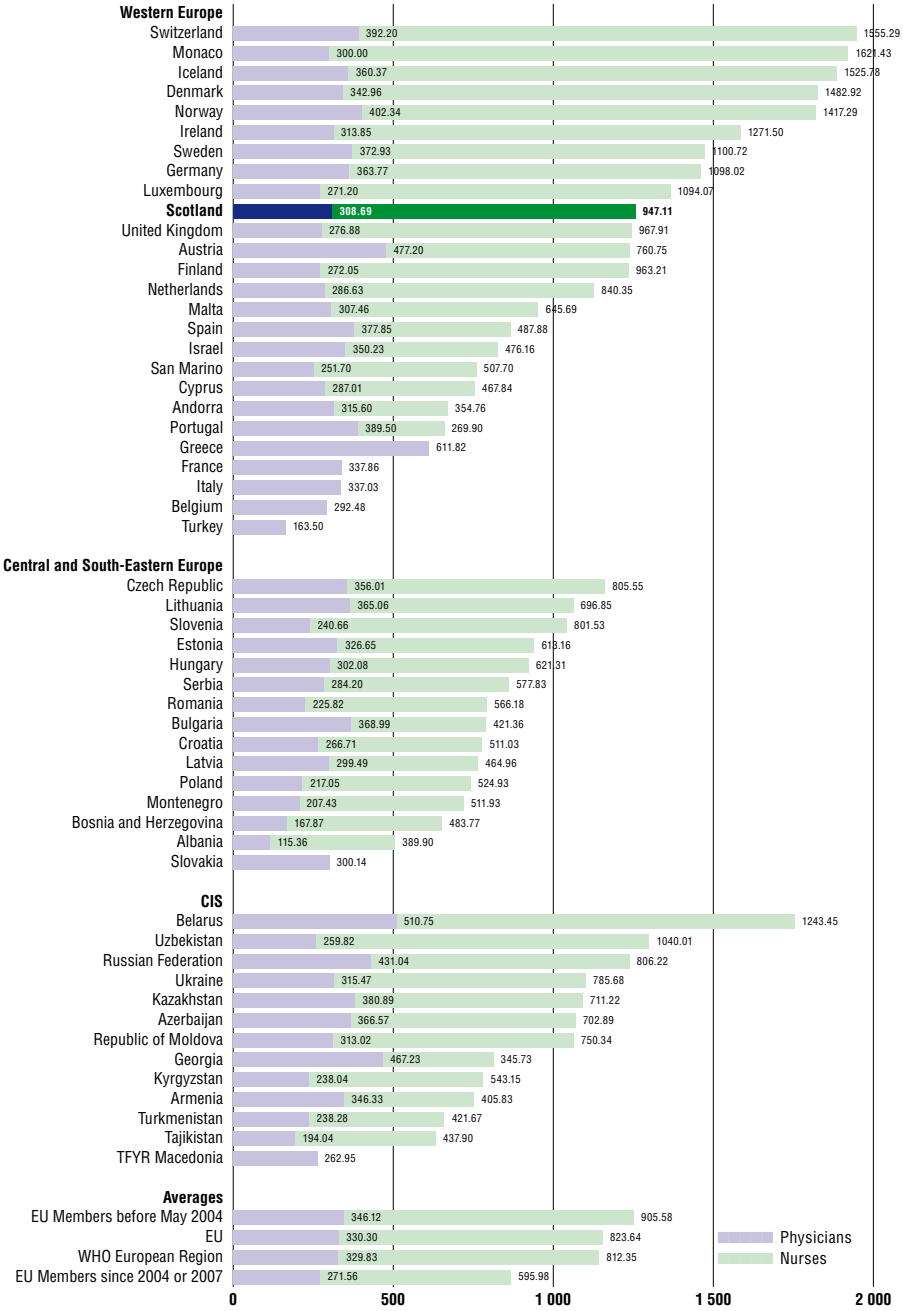


Source: WHO Regional Office for Europe, various years; data for Scotland from ISD.

Fig. 4.6 compares the number of physicians and nurses per 100 000 population in Scotland with the rest of Europe, and reveals (again with the qualification about the data, particularly in relation to nurses) that Scotland has a fairly high density of physicians and nurses, slightly higher than the United Kingdom overall, Austria, and the Russian Federation.

Fig. 4.6

Number of physicians and nurses per 100 000 population in the WHO European Region, latest available year



Source: WHO Regional Office for Europe, various years; data for Scotland from ISD.

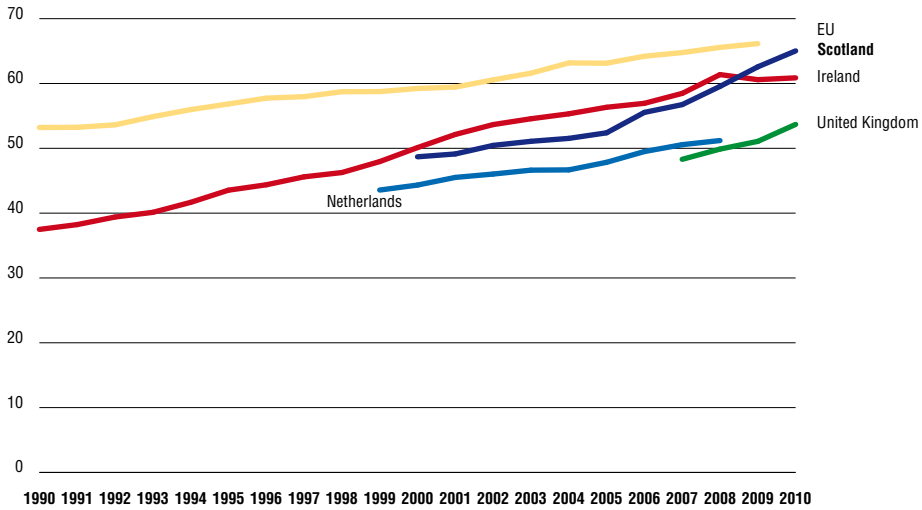
Dentists

In 2011 there were 3940 dentists working in hospital and community services, including dental public health, and in general dental services, an increase of almost 45% since 2002, reflecting government policy to increase numbers to improve oral health generally, and specifically to improve access to NHS dentistry.

Comparative European data on numbers of dentists per country suffer from significant differences in the way in which these figures are recorded. As Fig. 4.7 shows, in 2010 Scotland had 65 dentists per 100 000 population (again calculated to exclude double counting) in line with the EU average but rather higher than the United Kingdom overall.

Fig. 4.7

Dentists per 100 000 population, selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe, various years; data for Scotland from ISD.

Pharmacists

In 2011 there were 4266 registered pharmacists working in Scotland (Hassell, 2012). This equates to 82 per 100 000 population, which (with the same qualifications about data comparability) is significantly more than in the United Kingdom overall and above the EU average. ISD collects data only on those pharmacists employed by the NHS and thus not those working in

community pharmacy. On the basis that ISD recorded 1372 as hospital based in 2010, around 2900 worked in community pharmacy (Royal Pharmaceutical Society, 2012).

Allied health professionals

There are 11 professions that are known as allied health professionals (art therapy, chiropody/podiatry, dietetics, occupational therapy, orthoptics, orthotics, prosthetics, physiotherapy, diagnostic radiography, therapeutic radiography, and speech and language therapy). In 2011 there were 11 304 working in the NHS (9347 WTE), just over 7% of the workforce. Of these over 70% are in the three largest professions: physiotherapy, occupational therapy and radiography. The number of allied health professionals has grown by 23% over the last decade, reflecting the growth in numbers of older people and the increased emphasis on rehabilitation services.

Administrators

The second largest group of employees in the NHS is administrative staff, comprising 28 859 people (24 668 WTE) and 17.9% of the total. Their numbers have risen significantly over the last decade (18%), giving rise to adverse media comment about the growth in bureaucracy at the expense of direct patient care. However, many of the staff classified as administrators, such as ward clerks and medical secretaries, work in support of clinical staff, freeing up their time for patient care. The numbers of senior managers (as defined by the special pay scheme) in 2010 was 1255.

Support staff

Just under 12% of the NHS employees (18 767, 13 767 WTE) work in support roles such as estates, portering, catering and cleaning. Although their numbers have increased by 12% since 2002, since the mid-1980s there has been a significant reduction, reflecting the shift of services from hospitals to the community and the transfer of many catering and cleaning services to the private sector as a result of the policy of subjecting such services to competitive tendering and the outsourcing of facilities management as part of PPP/PFI schemes.

4.2.2 Training and career paths of health workers

Health worker training and career paths are similar throughout the United Kingdom. This section provides a brief summary and notes any areas where Scottish practice differs from that in England.

Doctors

A radical overhaul of medical training in the United Kingdom began in 2003 with the Modernising Medical Careers programme. There are four university medical schools in Scotland awarding their own medical degrees (Aberdeen, Dundee, Edinburgh and Glasgow). In addition, St Andrews provides training for the first three years of a medical course but the remaining years are provided elsewhere.

The undergraduate degree course is usually five years in duration and takes place under the overall supervision of the United Kingdom General Medical Council (GMC). Following graduation, new graduates enter a two-year foundation programme (F1 and F2) which involves several placements in various specialty and health care settings. Since 2010 the GMC has been responsible for approval and quality assurance of this programme following its merger with the Postgraduate Medical Education and Training Board.

Specialist training begins when an individual has completed F1 and F2. Specialist training curricula and assessments, drawn up by the medical royal colleges, and the distribution of training posts (known as specialty registrar posts) are approved by the GMC. In Scotland, a special NHS board, NHS Education for Scotland (NES), is responsible for managing the application and recruitment process to training programmes in partnership with territorial boards.

For doctors choosing to work in hospitals, specialist training lasts five to seven years. Once they have a certificate of completion of training they are placed on the GMC's Specialist Register and are eligible for appointment to a consultant post. The postgraduate training programme for general practice, the vocational training scheme, lasts for a minimum of three years, the first two of which are normally spent in posts in hospitals in specialties relevant to general practice, and the third working as a GP registrar in the practice of a GP trainer, after which the doctor is included on the GMC's GP Register and is eligible to work as a GP.

On average medical professionals will have spent at least 9 years in clinical training after graduation from medical school to become a GP or 11 years to become a hospital consultant. Most GPs work as partners under contract with the local NHS board but an increasing number work as salaried GPs. Within hospitals those who either choose not to become consultants or fail to gain a consultant post work as staff grade doctors, of which there were 1527 (1012 WTE) in 2011 (ISD, 2011k).

Doctors have a responsibility to maintain and develop their knowledge and skills through continuing professional development (CPD). The annual appraisal process, in place since 2001 for consultants and 2002 for GPs, and the five-yearly revalidation process being introduced from late 2012 is the means by which doctors demonstrate that their skills are being kept up to date and enhanced as prescribed in the GMC's guidance *Good medical practice* (GMC, 2006).

Dentists

There are four university dental schools in Scotland (Dundee, Edinburgh and Glasgow, and since 2008 Aberdeen) providing five-year undergraduate degree courses in dentistry. On completion of this training, registration with the United Kingdom General Dental Council (GDC) enables one to practise as a dentist. Further training is required to be registered on a specialist register, such as orthodontics, oral and maxillofacial surgery and paediatric dentistry.

Specialists mainly work in hospitals as NHS employees; other dentists are private contractors providing services to NHS patients in return for fees (see Chapter 5). NES is responsible for facilitating CPD for dentists and this will be one of the aspects of the revalidation process being introduced by the GDC from 2014.

Nurses and midwives

Training to become a nurse or midwife is provided through a pre-registration diploma (three years) or degree course (three or four years) offered by universities with placements in local hospital and community settings. From 2013 all courses will be at degree level. Nine universities currently provide nursing training courses under contract to the Scottish Government. The first year introduces students to the basic principles of nursing through a Common Foundation Programme. Students then specialize in adult, children's, mental health or learning disability nursing. Midwives must hold a degree in midwifery or, if already a qualified nurse, have completed a short additional training programme.

On completion of training, nurses, midwives and specialist community public health nurses (health visitors, school nurses and occupational health nurses) must register with the United Kingdom Nursing and Midwifery Council in order to practise. Re-registration is required every three years and nurses must undertake a minimum of five days or equivalent of learning activity every three years and maintain a personal professional profile containing details of their professional development.

Nurses work in a wide variety of hospital and community settings. Given the high proportion of women in the profession, many have broken careers and great efforts are made to encourage them to return to work after having children.

Pharmacists

Pharmacy is a graduate profession requiring a four-year Master of Pharmacy degree from an accredited university, of which there are 26 in the United Kingdom, 2 in Scotland – Robert Gordon (Aberdeen) and Strathclyde) – followed by a year's practical training in a community or hospital pharmacy. To practise, a pharmacist must be registered with the Great Britain General Pharmaceutical Council, which also regulates pharmacy technicians and pharmacy premises.

Allied health professionals

The allied health professions are graduate professions, requiring an honours degree (four years in Scotland) in order to register to practise with the United Kingdom Health Professions Council and in some cases, at postgraduate level.

4.2.3 Partnership working

Since 1998 the concept of partnership working has been developed as the approach to employee relations (Scottish Office, 1998c). Led by a Scottish Partnership Forum, co-chaired by the Chief Executive of the NHS (or Director of Human Resources) and a leading trade unionist, partnership structures – involving trade unions, managers and, at national level, government – have been put in place nationally and locally to involve staff in key decisions on strategic, workforce and operational issues (Bacon & Samuel, 2012).

These developments are underpinned by "staff governance" – a system of corporate accountability for the fair and effective management of staff (Scottish Executive, 2002a, 2004f). All boards are expected to meet the Staff Governance Standard, which sets out what is expected to demonstrate that staff are well informed, appropriately trained, involved in decisions that affect them, treated fairly and consistently, and provided with a safe working environment (Scottish Government, 2007f); and are required to have a Staff Governance Committee to provide assurance that this is happening. An employee director also serves as a non-executive on each board.

5. Provision of services

Increasing emphasis has been given to NHS boards' lead role in improving population health, reflecting growing concern about Scotland's health problems. Key public health developments include a ban on smoking in public places, raising the age for purchasing tobacco from 16 to 18 and introducing a minimum unit price for alcohol (agreed in principle by the Scottish Parliament in 2012). Around 90% of patient contact is with primary care and most patient journeys begin and end in primary care, where GPs increasingly work as part of multidisciplinary teams involving nurses, midwives, health visitors, allied health professionals and managers. In recent years all the services provided by the NHS have been subject to change designed to improve their quality, effectiveness and efficiency. Common themes have been: improving health outcomes; improving access; providing services in the community in partnership with local authorities and the third and independent sectors; strengthening anticipatory and preventive care; involving patients and carers in decisions; and increasing productivity.

5.1 Public health

Reflecting growing concern about Scotland's health problems, increasing emphasis has been given to NHS boards' lead role in improving population health, working in close partnership with other agencies. Successive strategic documents have given as much emphasis to improving population health as to improving health care and have underlined boards' role as "public health organizations" (Scottish Executive, 2000c).

Most recently, *Better health, better care* (Scottish Government, 2007a) highlighted the health improvement agenda and set out actions to: increase HLE in Scotland; break the link between early life adversity and adult disease; reduce

health inequalities, particularly in the most deprived communities; and reduce smoking, excessive alcohol consumption and other risk factors to a healthier life. The Scottish Government also undertook to complete the passage of legislation to modernize the law relating to public health (enacted as the Public Health etc. (Scotland) Act 2008), prompted in part by growing concern about health protection as a result of developments such as new intensive methods of food production, the globalization of trade and travel, and increasing pressure on the environment, which have contributed to the re-emergence of infections such as tuberculosis and new threats such as SARS.

5.1.1 Organization of public health services

Government, NHS and local authorities have specific but shared responsibilities for public health. The national lead for improving public health in Scotland is the Chief Medical Officer, a post that sits within the health directorates but which has a remit across government. The NHS, nationally and locally, has been given lead responsibility (and there are no plans to alter this as is currently happening in England) but, as better health also comes from social, environmental and economic improvement, local authorities and other public agencies, employers, trade unions and voluntary organizations are all key players (Box 5.1).

There are two major national public health programmes: the immunization and national screening programmes.

Immunization

Scotland has a comprehensive programme of immunization available through the NHS. The provision of such programmes is guided on a United Kingdom basis by the Joint Committee on Vaccination and Immunization. Most vaccinations are undertaken in primary care.

The national immunization programme focuses on three groups:

- children, providing protection against diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b (Hib), polio, meningococcal serogroup C (MenC), measles, mumps and rubella (MMR) and pneumococcus. Since 2008 vaccination has also been offered to girls aged between 12 and 13 against the human papillomavirus in order to reduce subsequent risk of cervical cancer (with a catch-up campaign for girls aged 14–18).

Box 5.1

Organization of public health services

Scottish Government		
Overall responsibility for public health led by Chief Medical Officer and health directorates but involving all directorates		
Scotland-wide	**Local**	**United Kingdom**
NHS Health Scotland National agency for improving population health, running media campaigns and providing resources for use by the NHS and others such as schools and workplaces	**NHS boards** Lead role in protecting and improving health of local population, working in partnership with other public, private and voluntary organizations	**Health and Safety Executive (HSE)** Regulates health and safety at work
Health Protection Scotland (HPS) Part of NSS; surveillance and coordinating centre for communicable diseases, infection control and environmental health hazards	**Local authorities** Lead role locally on environmental health issues, and responsible for services such as education and housing that have a major impact on public health	**Health Protection Agency (HPA)** Coordinates health protection across United Kingdom and leads on a few reserved issues
Scottish Public Health Observatory Collaboration Publishes reports and other information on health of population		**Food Standards Agency (FSA)** FSA Scotland, part of United Kingdom FSA, protects the public's health and consumer interests in relation to food
Scottish Environment Protection Agency (SEPA) Regulates activities that cause harmful pollution and monitors quality of air, land and water		

- older people (aged 65 or over) who are offered a single dose of pneumococcal vaccine if they have not previously received it and an annual influenza vaccination. Vaccinations are offered to any adult with an underlying medical condition (e.g. chronic respiratory disease) or otherwise at higher risk.
- health care and laboratory staff, both for their own protection and to avoid transmission of diseases between patients, who are kept up to date with routine vaccinations and offered others if they are working in certain areas or with certain groups of staff.

National screening programmes

Screening policy is set by the Scottish Government on the advice of the United Kingdom National Screening Committee and other appropriate bodies. The National Services Division of NSS is responsible for commissioning and coordinating important elements of seven national screening programmes.

Box 5.2

National screening programmes

Programme	Date of introduction	Coverage
Bowel screening	2007–2009	Men and women aged 50–74 every two years
Breast screening	1988–1991	Women aged 50–70 every three years (those aged 71+ encouraged to self-refer)
Cervical screening	1989	Women aged 20–60 every three years
Diabetic retinopathy screening	2003–2006	People with diabetes aged 12+ annually
Newborn blood spot screening	Long-established	All newborn babies, usually around five days old
Pregnancy screening	(1) Long-established (2) 2008–2011	All pregnant women for (1) various communicable diseases and for Down's syndrome at 12 weeks; and (2) for fetal anomalies between 18 and 21 weeks
Universal newborn hearing screening	2005	All babies within first few weeks

A key development, which some commentators have regarded as the most important public health measure of recent years and on which Scotland led the way in the United Kingdom, was the passage of legislation to ban smoking in public places and to increase the minimum age for purchasing tobacco from 16 to 18. This came into effect in 2006. Scotland has also pioneered action to curb alcohol consumption, banning multi-buy discounted selling of alcohol in 2011 and introducing a minimum unit price (agreed in principle by Parliament in 2012).

5.2 Primary care

Primary care services are provided by a range of health care professionals in a variety of non-hospital settings. They are normally the first point of contact with the NHS. Primary care also has a "gatekeeper" role in relation to secondary and tertiary services. An estimated 90% of patient contact is with primary care and most patient journeys begin and end in primary care. There are 23 million consultations each year with a GP or practice nurse, with each patient on average seeing their GP three times a year (ISD, 2011l).

The term "primary care" is often used to refer to the practitioner services provided by independent contractors, of which there are four: medical, dental, pharmaceutical and optical. However, primary care also includes the many health care professionals who work in partnership – increasingly as part of teams – with these practitioners. For example, in primary medical care which is the focus of this section (dental and pharmaceutical services are covered in

separate sections of this chapter) the focal point is the GP or the GP practice comprising a group of GPs working together to provide a range of preventive, diagnostic and curative services. Increasingly, however, GPs work as part of a multidisciplinary primary care team including nurses, midwives, health visitors, allied health professionals and managers, some employed directly by the practice, others employed as community staff by the local NHS board.

5.2.1 Organization and provision

Unlike in England, overall responsibility for primary care has always lain with health boards. Overseeing of primary care has, however, been delegated by boards to primary care administrators, then in the 1990s to primary care trusts, then after 2000 to local health care cooperatives and, since 2008, to CHPs.

In 2011 there were 4937 GPs and 1009 GP practices in Scotland; the number of GPs has increased by 13% since 2002 (ISD, 2011f). Most GPs (87% of practices) are independent contractors who provide services to the NHS under the new General Medical Services Contract (nGMS) introduced in 2004. The remainder have either entered into a Personal Medical Service contract with the local board (9%) or are directly managed by the board using salaried GPs (4%). The number of salaried GPs, either within GP practices or employed by NHS boards, has increased significantly over recent years but is still small (533 in 2011; ISD, 2011f). This arrangement has provided some greater flexibility in providing services to remote, rural and deprived areas.

Traditionally, GPs were responsible for their patients 24/7, operating an on-call rota within their practice or with other practices. Such sharing became increasingly widespread during the 1990s through the development of out-of-hours cooperatives, owned and managed by GPs, which eventually covered around 75% of patients. As part of the nGMS contract, practices could choose not to provide out-of-hours services (weekday evenings, weekends and public holidays) for their patients, in which case responsibility for delivering these services is transferred to the local board. Ninety-five percent of practices have decided to "opt-out", the main exceptions being in remote areas (88% of such practices, which cover 1.3% of the population, are in the areas of Highland and the three Island boards) where it would be difficult to make alternative, sustainable provision (ISD, 2011m). Out-of-hours patients contact NHS 24 (such calls account for 90% of its call volume) in the first instance, where a triage system decides how their needs can be met most appropriately. Boards provide out-of-hours services by contracting with a range of providers, including a significant number of GPs who have opted-out, or by directly employing staff including salaried GPs (Audit Scotland 2007).

5.2.2 Access and quality

Every United Kingdom citizen has the right to be registered with and to consult their GP practice without charge. Patients have freedom to choose a GP practice, subject to their list being open and their being willing to accept them, which normally means that they live within the geographical area served by the practice. Patients can choose to see any of the doctors in the practice and often they see whoever is available.

Access to GPs is rated as a high priority for patients. One of the HEAT targets requires that 90% of patients should have contact with a health care professional in primary care within 48 hours of requesting it. In recent years this target has been exceeded (with 93% of people in 2011/2012 able to access an appropriate member of the practice team within 48 hours) (Scottish Government, 2012g).

In 2008 a flexible GP hours scheme was introduced under which participating practices receive payment for providing additional consultation time on weekday evenings and early mornings, and Saturday mornings. Subsequently additional funding was provided to enable practices to employ nursing support staff during extended hours. Within a year of its introduction around two-thirds of practices participated in this scheme.

Prior to 2004, funding for GPs was based primarily on the number of patients, not linked to performance or quality. The new contract introduced a system of financial incentives for delivering clinical and organizational quality – the Quality & Outcomes Framework (QOF). The QOF is voluntary but, to date, most nGMS practices in Scotland have participated fully. The QOF measures a practice's achievement against a scorecard of evidence-based indicators. These indicators span four domains: clinical, organizational, patient experience and additional services. In 2010/2011, practices could score up to a maximum of 1000 points across 134 indicators. The average number of points earned by nGMS practices was 976.3 and QOF payments accounted for 19% of practice income (ISD, 2011o). QOF performance has from the outset been significantly higher than predicted (and budgeted for), suggesting that the targets were not as demanding as they might have been (e.g. McDonald et al., 2010).

5.2.3 Recent developments

In 2010, following publication of the *healthcare quality strategy,* an action plan was produced for primary care: *Delivering quality in primary care national action plan* (Scottish Government, 2010e). Its commitments included:

- ensuring that the contracts with independent contractors support the delivery of quality care;
- improving access for patients;
- implementing a patient safety programme in primary care;
- developing a suite of agreed care pathways, focusing initially on conditions for which primary care has greatest impact such as diabetes, asthma and dementia;
- developing national quality standards for primary care out-of-hours services;
- enhancing the contribution of primary care to primary prevention and anticipatory care.

5.3 Specialized ambulatory inpatient care

Secondary and tertiary care are provided mainly in hospital settings on an inpatient, day-case or outpatient basis. In Scotland such care is provided almost entirely by the NHS but there is a small amount of private sector provision.

5.3.1 Organization and provision

NHS secondary and tertiary care is provided by salaried specialist doctors (known as consultants), staff grade doctors, doctors in training, nurses, allied health professionals, pharmacists and others. Most of these services are hospital-based but there is some outreach, for example in rural areas where consultants hold clinics in outlying areas. Almost all these hospitals are owned and run by the NHS. As a result of the PPP/PFI initiative there are a number, including four major acute hospitals, which are owned privately and leased to the NHS. Clinical services in these hospitals are run by the NHS.

In Scotland there have been no NHS trusts since 2004 and there are no foundation trusts. Responsibility for planning and managing hospital services lies with NHS boards but with day-to-day operational responsibility delegated to operating divisions.

There are seven teaching hospitals providing tertiary care for more complex or rare conditions on a regional or, in some cases, national basis, as well as secondary services for the population in the area in which they are located. In addition there are five single specialty hospitals providing tertiary children's,

maternity or dental services, and the Golden Jubilee Hospital in Clydebank, which undertakes elective orthopaedic surgery and is the cardiothoracic centre for the west of Scotland.

The largest group of hospitals are known as district general hospitals of which there are 30 in Scotland. There is no single definition of a district general hospital and they vary both in size from over 600 beds to around 80 beds on the mainland (and even fewer in the Island hospitals) and the range of services they provide (ISD, 2011r). There are 37 specialized services commissioned by the National Services Division of NSS on the grounds that they need to be provided on a supra-regional basis, mainly but not entirely from tertiary centres, such as liver transplantation, adult cystic fibrosis services, spinal injuries services and paediatric intensive care.

Hospital services are provided by teams of health care professionals under the leadership of a consultant. Efforts have been made in recent years to increase the proportion of care actually provided by consultants and their numbers have increased by just over 40% since 2002 (ISD, 2011k).

The sustainability of a large hospital network in terms of clinical safety, staffing and costs was a major driver of the decision to set up the National Framework for Service Change group in 2004. Its report, and the subsequent policy document *Delivering for health* (Scottish Executive, 2005b, 2005d) recommended the concentration of specialized and complex care on fewer sites to secure clinical benefit and manage clinical risk, but its maxim of "as specialized as necessary and as local as possible" discouraged actual hospital closures. The report also promoted the development of networks of rural hospitals to support rural communities and further development of managed clinical networks and processes, such as telemedicine, to make specialist expertise available in small and more remote centres.

Key trends over the period 2001 until 2011 include (ISD, 2012a; Scottish Government, 2012b):

- a continuing decline in the number of staffed acute beds by 7.7% (after a steep fall in the previous 20 years)
- an increase in routine inpatient discharges in acute specialties by 25%
- an increase in non-routine (emergency) inpatient discharges by 10%
- an increase in day-case discharges by 16.5%
- a fall in the average length of stay from 6.5 days to 5.3 days

- an increase in the average number of inpatient discharges treated per bed (i.e. throughput) by 23% (2002–2011).

5.3.2 Access and quality

To access NHS specialist care patients require a referral, in most cases from a GP unless they are admitted as an emergency. Normally this will be to their local hospital but GPs are able to refer a patient to any NHS hospital or named consultant. Information about the range of services available and the performance of individual hospitals and consultants is provided to enable GPs and patients to make informed choices. Most secondary hospital services are available in all mainland boards in Scotland and a more limited range in the Islands.

Over the last 20 years, governments in all parts of the United Kingdom have sought to reduce waiting times by setting a range of targets. The current standards are that 90% of planned/elective patients should commence treatment within 18 weeks of referral – known as the Referral to Treatment (RTT) standard – and that no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic. In December 2011, 92% of completed patient journeys for which RTT measurement was possible (87.5% of patient journeys) were reported as being within 18 weeks. The number of patients who were waiting over 12 weeks for an outpatient consultation was 5537 (2.7% of patients on the list). Boards are also working to deliver the guarantee in the Patient Rights (Scotland) Act that each patient will receive inpatient or day-case treatment within 12 weeks, which is due to come into force from October 2012. During the quarter ending 31 December 2011, 904 patients (1.0% of those seen) waited more than 12 weeks (all data from ISD, 2012e).

A new system of recording waiting time data was introduced in 2008 and further refinements have been made subsequently. This makes time series comparisons difficult. Differences in the way data are collected also make comparison across the United Kingdom very difficult (but not impossible – see section 7.4.2 *Health service outcomes and quality of care*).

Other waiting time targets have been set for specific services (in addition to those for a GP appointment, at emergency departments and mental health services, which are covered in sections 5.2, 5.4 and 5.10 respectively):

- 95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral (from end 2011);
- maximum six-week wait for eight key diagnostic tests (e.g. endoscopy, CT and MRI scans) (from 2009).

Although based wherever possible on whole patient journeys, the standard setting and service review activities of HIS and its predecessor bodies have tended to focus on hospital services. Similarly the focus of the Healthcare Environment Inspectorate's work on health care-associated infection has been on hospitals and the initial phase of the Scottish Patient Safety Programme was directed to improving safety in acute hospitals. A biennial patient experience survey is conducted as part of the Better Together programme (Better Together, 2012).

5.4 Emergency care

The terms "emergency care" and "unscheduled care" are used variously and there is no agreed definition of what constitutes an emergency. Similarly, the range of services provided by emergency departments varies in different parts of Scotland and there is ambiguity about the distinction between emergency departments and minor injuries units.

5.4.1 Organization and provision

The emergency care system in Scotland comprises emergency departments (often referred to as accident and emergency – A&E – departments) and minor injuries units, the ambulance service and NHS 24. There are 35 emergency departments and 59 minor injuries units in all parts of Scotland, run by NHS boards (Audit Scotland, 2010).

The Scottish Ambulance Service is a national organization providing A&E and patient transport services in all parts of Scotland from 180 locations. All operations are coordinated from three emergency medical dispatch centres shared with NHS 24. Sixty percent of frontline A&E staff are now trained paramedics and this is reflected in an increasingly clinical focus to its work (SAS, 2011). In addition to running a range of road transport vehicles, an air ambulance service (with two fixed-wing aircraft and two helicopters) operates from three bases. In rural areas the ambulance service is supported by volunteer

Community First Responders, trained in first aid and resuscitation procedures. In 2011 there were over 1000 such volunteers working in around 120 schemes (SAS, 2011).

NHS 24 is an online and telephone service. One of its functions is to receive calls from people needing health services, particularly out of hours when GP surgeries are closed. Following triage, callers are put though to an appropriate health professional who may recommend self-treatment at home, seeing a doctor or another health professional at a GP surgery, an out-of-hours centre, at a community pharmacy or by going to an emergency department either independently or by ambulance (NHS 24, 2011).

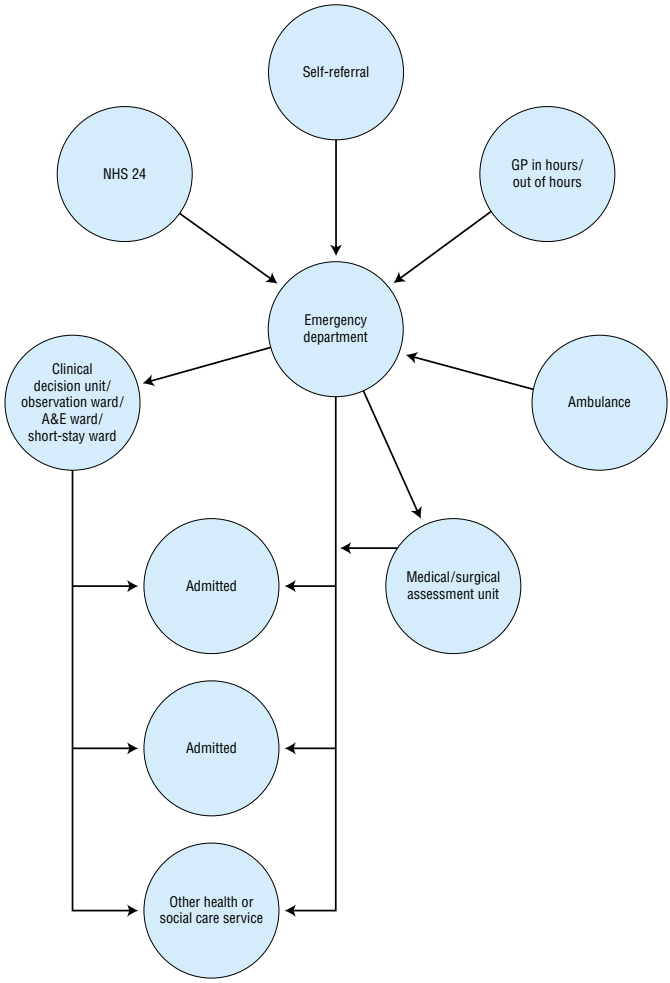
Close collaboration among all these services is essential. This is facilitated by the electronic ECS, available to all ambulance staff.

5.4.2 Access and quality

Patients can access emergency departments in a number of ways: by self-referral or referral by an emergency service, NHS 24 or a GP (Fig. 5.1). In 2008/2009, 74% of emergency cases either decided to go themselves or were taken by an ambulance (around 56% of all attendances were estimated to be self-referrals without any prior contact with a health care professional). GP referrals constituted about 10% of attendances with significant variation in different areas reflecting local practice on whether such referrals should be admitted to hospital via the emergency department or directly to a ward; the remainder came via NHS 24, out-of-hours services or minor injuries units.

Waiting time targets are in place for all emergency care services. Despite a 31% increase in emergency demand for the ambulance service between 2004/2005 and 2008/2009, response times improved (Audit Scotland, 2010). In 2010/2011, 72% of life-threatening calls were responded to within 8 minutes compared with 55% in 2004/2005 with an average response time of 6.9 minutes. There is some variation in performance reflecting distances in remoter areas of the country. Of urgent requests from GPs, 91.2% were dealt with within one hour (against a target of 91%) (Audit Scotland, 2010; SAS, 2011). Calls to NHS 24 have also increased but the service performs well against the national target of 90% of calls to be answered within 30 seconds, achieving over 94% in 2010/2011 (NHS 24, 2011).

Fig. 5.1
Emergency care patient pathways



Source: Audit Scotland, 2010.
Note: There may be local variation in patient flows into emergency department and between services.

In 2004 the then Scottish Executive set a target that, by the end of 2007, 98% of patients attending an emergency department should wait no longer than four hours from arrival to admission, transfer or discharge. During 2011 performance against this target was 96% (ISD, 2011u). Boards have achieved this through changing working practices, for example introducing fast-track systems for minor injuries.

There is only limited national reporting monitoring and benchmarking on the quality and clinical effectiveness of care provided by emergency departments, with only just over half of the emergency departments monitoring performance against standards set by the College of Emergency Medicine. The ambulance service has a number of clinical targets. Against a target range of 12–20% survival of cardiac arrest patients at point of arrival at hospital, a rate of 14.5% was achieved in 2010/2011; 75.5% of patients suffering from hyper-stroke reached hospital within an hour of presentation to the ambulance service (against a target of 80%) (SAS, 2011).

Patient satisfaction with the service from emergency departments is generally high, 82% of respondents to a recent survey rating the service as good or excellent. Unsurprisingly, there is a link between how long people wait and levels of satisfaction (Better Together, 2012). For those who contacted NHS 24 almost 75% rated the service excellent or very good. Satisfaction with the ambulance service was also high, 86% rating it as excellent or very good (NHS 24, 2011).

5.5 Pharmaceutical care

Pharmaceutical care accounts for a significant and increasing proportion of NHS expenditure (14.6% of boards' operating costs in 2010/2011; ISD, 2011r). This section focuses on the organization of pharmaceutical services in Scotland, the supply of medicines to patients in the community and in hospital, and the role of pharmacists as members of the health care team. It does not cover the manufacture of pharmaceuticals, the licensing and regulation of medicines, or the control of pharmaceutical prices as these are all undertaken at United Kingdom level and are discussed comprehensively in the *United Kingdom (England) HiT* (Boyle, 2011).

5.5.1 Organization and provision

There are 4266 registered pharmacists in Scotland, most working in community pharmacies or in hospitals. The remainder work in other areas of pharmacy, such as industry or higher education. Around 2900 pharmacists work in 1231 community pharmacies across Scotland. These are contracted by the NHS to provide pharmaceutical services. Around 40% are owned by companies that have seven or more shops. Traditionally their main role has been to dispense

prescriptions and sell non-prescription items. The number of prescriptions has grown steadily and in 2010/2011 over 91 million prescriptions were dispensed (Scottish Government, 2012b).

Pharmacists have always provided advice to patients. Their role has been extended and formalized by the new contract that was negotiated following publication of *The right medicine* (Scottish Executive, 2002b) so as to make services more accessible to patients and to reduce pressures on other parts of the NHS. All pharmacies are now expected to provide additional services (Box 5.3).

Box 5.3

Extended community pharmacy services

Service	Date of introduction	Description
Minor Ailment Service	2006	Treatment of various common conditions without need to visit GP
Public Health Service	2006	Smoking cessation and sexual health services plus general public health information
Acute Medication Service	2008	Computerized check of prescriptions by pharmacists against patient's records
Chronic Medication Service	2010	Management of patients with long-term conditions

Equivalent developments have occurred in hospital pharmacy for which boards employ 1372 pharmacists. Audit Scotland found that all boards had a clinical pharmacy service (with pharmacists working directly with patients and other staff in wards and clinical areas) but that it was available in only two-thirds of hospitals, and even in these hospitals only in some specialties (Audit Scotland, 2005, 2009b).

5.5.2 Access and quality

Pharmacy contracts are governed by the Control of Entry Regulations and are awarded on grounds of necessity and desirability. An Essential Small Pharmacy Scheme exists to ensure that small, especially rural, communities receive pharmacy services. In some isolated communities GPs provide dispensing services and it can be controversial when a commercial pharmacy seeks to open in such areas as the GP would lose a significant element of remuneration.

User charges for prescriptions were abolished in 2011 (see section 3.4.1 *User charges*). The (United Kingdom) Medicines Act 1968 specifies which medicines can be purchased "over the counter" and which are available only on prescription. Any medicine also needs to be licensed by the (United Kingdom) Medicines and Healthcare products Regulatory Agency or the European

Medicines Agency, which require evidence that it has been shown to be safe and effective in a clinical trial. Medicines are usually licensed for use in treating a particular illness or condition.

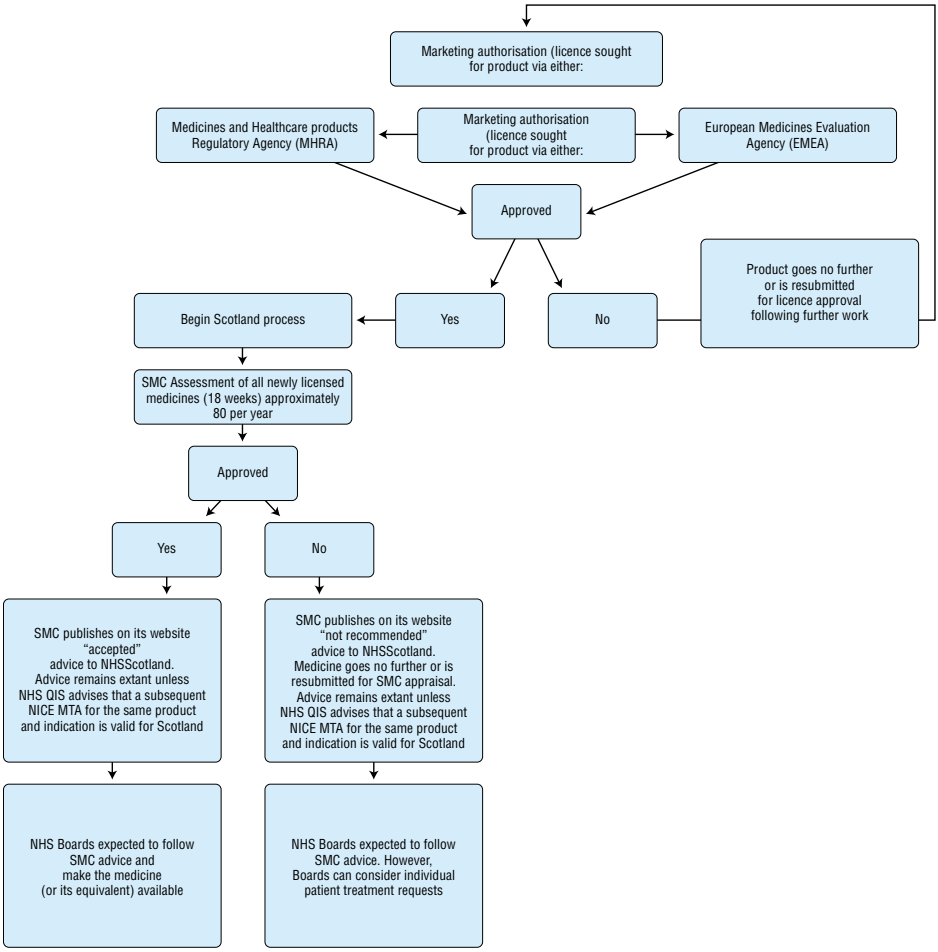
Across the United Kingdom, there are restrictions on which licensed medicines can be prescribed through the NHS. Locally each NHS board, through its area drugs and therapeutics committee (ADTC), has also developed formularies that list the drugs that GPs and other prescribers may use. Even if a medicine is not on the local formulary a doctor can still prescribe it if he or she considers this is clinically appropriate.

As far as new medicines are concerned (of which there are 80–90 each year), each ADTC in the past used to undertake its own appraisal prior to a decision on inclusion in its formulary. To streamline the process and avoid geographical variability in the availability of medicines, the Scottish Medicines Consortium (SMC) was established in 2001 as a consortium of ADTCs. Once it has obtained a licence for a new medicine, a pharmaceutical company is expected to provide evidence to the SMC to enable it to assess its clinical and cost-effectiveness for use in the NHS. The SMC produces its advice within 18 weeks, which all boards are expected to follow. Special arrangements have been introduced for use of medicines not recommended by the SMC exceptionally in the treatment of individual patients. These processes, which are complex, are summarized in Fig. 5.2.

A specific issue has been that of "top-up" payments by patients for medicines – mainly for the treatment of cancer – not available through the NHS. Until 2009 patients who made such payments were excluded from those elements of their NHS care that would have previously been free. Following a review, the Scottish Government decided that, under certain circumstances, such patients would still receive the rest of their care free from the NHS (Scottish Government, 2009a).

The General Pharmaceutical Council (GPhC) is the independent regulator and registration body for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. In order to practise, pharmacists and pharmacy technicians must be registered with the GPhC and must work from premises that are registered as compliant with all legal requirements and regulatory standards. Registration has to be renewed annually and premises are inspected at least once every five years.

Fig. 5.2
Approval process for new medicines



Source: Scottish Government, 2010i.

Pharmacy practice also features prominently in the standards set by HIS and the National Care Standards Committee for particular services and care pathways. It has also been a core element of the Scottish Patient Safety Programme, which includes a Medicines Management workstream designed to provide safe and effective medicines management by reducing adverse drug events associated with high-risk processes and medicines, for example, medicines at the interfaces between staff or parts of the service, and anticoagulation.

5.5.3 Recent developments

In October 2011 the Scottish Government announced a review of NHS Pharmaceutical Care in the Community to further enhance the role of pharmacists and encourage closer working with GPs and other community-based services. It will examine the suitability of current arrangements for providing NHS pharmaceutical services and their long-term sustainability. The findings are expected in autumn 2012 and will help shape the Scottish Government's programme for pharmaceutical care and medicines for the next five years.

5.6 Rehabilitation and intermediate care

Intermediate care encompasses a range of functions that focus on prevention, rehabilitation, enablement and recovery so as to prevent unnecessary hospital admission, delayed discharge from hospital and premature admission to long-term care. As a result it is not just a health or social care agenda but also needs to involve housing, and the third and independent sectors – alongside families, carers, neighbours and the wider community.

5.6.1 Organization and provision of services

Comprehensive information about the provision of intermediate care services is not readily available. Services are provided by the NHS and local authorities but with significant third sector and independent sector input. There is no single model of intermediate care and the pattern of service provision varies widely. *Co-ordinated, integrated and fit for purpose: the delivery framework for adult rehabilitation in Scotland* (Scottish Government, 2007c) provided strategic direction and support to health and social care services in the delivery of rehabilitation or enablement services.

Much progress has been made on implementation of the rehabilitation framework, many services having undertaken major redesigns. More, however, needs to be done to implement integrated models of delivering seamless rehabilitation services and a delivery plan for allied health professionals is under development to promote more flexible multidisciplinary teamwork, and closer partnership between health and social care practitioners.

Although intermediate care is primarily a home-based service model, for some people it is not possible to deliver intermediate care in the home environment. In this case, a community hospital or care home can provide a

suitable environment for recovery closer to home. There are 58 community hospitals in Scotland. Their distribution reflects history rather than a plan and they tend to be located in small towns in rural areas; for the same reason there is also wide variation in the services they provide. They are invariably highly valued within the community in which they are based.

In 2006 a strategy was published setting out a new role for community hospitals as part of an extended primary care system, providing local access to a wide range of services, wherever possible on a 24/7 basis, and promoting a multidisciplinary, multi-sectoral approach to health care (Scottish Executive, 2006c). CHPs were encouraged to use existing community hospitals as a platform to provide a bridge between home and specialist hospital care, through both ambulatory and/or inpatient services, not only in rural areas but also in larger towns and cities.

5.6.2 Access and quality

Data are collected on two measures of the effectiveness of intermediate care: preventing unnecessary acute hospital admissions and supporting timely discharge from hospital. From April 2012, there is a new HEAT target to reduce emergency bed day rates for those aged 75 and over by at least 12% nationally between 2009/2010 and 2014/2015. Additionally, in 2001 there were more than 2000 patient discharges delayed longer than six weeks; a target to reduce this number to zero by 2008 was achieved and subsequently numbers generally remain below 100. However, delayed discharges still account for almost a quarter of a million bed days and cause considerable distress and anxiety. A new target has therefore been set of reducing to zero the number of delayed discharges over four weeks by 2013 and over two weeks by 2015 (Scottish Government, 2012d).

5.6.3 Recent developments

A new framework document *Maximising recovery and promoting independence: intermediate care's contribution to reshaping care,* and *Community hospitals strategy refresh* setting out the vision for community hospital development were issued in 2012 (Scottish Government, 2012a).

5.7 Long-term care

This section outlines provision of long-term care for older people, people with chronic conditions such as diabetes and asthma, and people with learning difficulties.

5.7.1 Older people

Approximately £4.5 billion of public funding is spent each year on health and social care for those over 65 years (Scottish Government, 2010j). Well over half (60%) of this is spent on care in hospitals and care homes (and almost one-third on emergency admissions to hospital). Less than 7% is spent on home care. Overall, emergency admissions of older people absorb £1.4 billion each year and are expected to grow unless action is taken.

Organization and provision of services
Most older people (89.5%) do not receive "formal" care in NHS continuing care, a care home or a home-care service organized by social care agencies. For many this is because they do not need any assistance, while for others assistance is provided by family and friends, or organized and purchased privately.

In 2008/2009 there were 1.1 geriatric beds in Scotland per 1000 population (ONS, 2010). The number has decreased significantly but is still almost three times more than in England (0.4). The number of older people in care homes in 2010/2011 was 30 890 (Scottish Government, 2011a).

Access and quality
As a result of constraints of funding or limited availability of services many older people receive sub-optimal care that does not meet their needs and there is also a large amount of unmet need.

A series of reports, for example from the Scottish Public Services Ombudsman, have highlighted serious inadequacies in the clinical care of older people, in the dignity with which they are treated, in their nutritional status, and in communication both with older people themselves and their relatives (see for example SPSO, 2012). This has prompted questions about the adequacy of the arrangements for monitoring standards of care (Scottish Parliament, 2011).

The Care Inspectorate (formerly the Care Commission) is responsible for registering and inspecting care homes, using national care standards set by the Scottish Government and is in the process of increasing the frequency of its inspections. NHS provision for older people falls within the remit of HIS. Its predecessor organization, NHS QIS, undertook a review of NHS acute care for

older people in 2004 using hip fracture as a tracer condition; HIS has recently commenced a programme of inspections of NHS acute hospital services for older people.

Recent developments

Reshaping care for older people: a programme for change 2011–2021 (Scottish Government, 2010j) sets out an ambitious plan, developed by the Scottish Government, the NHS and the Convention of Scottish Local Authorities for reshaping care for older people across Scotland, along with the first set of key actions required to deliver it. It sets out the national framework, within which local partnerships are developing joint strategies and commissioning plans. A new £70 million Change Fund has been established as a catalyst to reshape care between 2011 and 2015. By 2012 Change Plans had been submitted by all health and social care partnerships in Scotland, detailing how they intend to use the Change Fund to enhance community services and increase preventive support.

5.7.2 People with long-term conditions

Around 2 million people in Scotland have at least one long-term condition, and one in four adults over 16 report some form of long-term illness, health problem or disability. By the age of 75, nearly two-thirds of people will have developed a long-term condition. Of people aged 75–84, 27% have two or more such conditions (Scottish Government, 2009c).

Organization and provision

Delivering for health (Scottish Executive, 2005d) sought to introduce a systematic approach to managing long-term conditions. Its priorities were, first, to identify those people at greatest risk of hospital admission and provide them with earlier care to prevent the deterioration of their health and, second, to equip people at all levels to manage their own health, enabling them to take greater control of their condition and of their life.

Better health, better care (Scottish Government, 2007a) committed the Scottish Government to producing a delivery plan for the next stage of work on long-term conditions, and this was published in 2009 as *Improving the health and wellbeing of people with long-term conditions in Scotland: a national action plan* (Scottish Government, 2009c). It set out an approach to the management of long-term conditions based upon the Wagner Chronic Care Model (Wagner, 1998), adapted to reflect NHSScotland's integrated system, with its focus on quality improvement and emphasis on a mutual care approach.

A Long-Term Conditions Collaborative, established in 2008, was tasked with supporting NHS boards to deliver sustained improvements in the quality of care provided for people with long-term conditions.

Access and quality

The action plan is designed to improve both access to appropriate support and services and the quality of service provision. The diverse nature of long-term conditions renders it impossible to assess progress in either area on a generic basis. Progress is monitored through the National Performance Framework, HEAT targets and the Community Care Outcomes Framework.

5.7.3 People with learning disabilities

It is estimated that there are around 120 000 people in Scotland with learning disabilities. Of these, about 25% are children and young people under 16, and a further 25% are people with complex needs. Evidence suggests an increase of 1% a year in the prevalence of learning disabilities due to improved survival rates of people with complicated medical and physical needs, together with increasing life expectancy (NHS QIS, 2009).

The same as you? A review of services for people with learning disabilities (Scottish Executive, 2000d) provides the strategic context for service development. A key recommendation was that all long-stay hospitals for people with learning disabilities should close by the end of 2005, with appropriate support and services in place within the community not only for those people leaving hospital, but also for people living in the community who may have had to rely on these hospitals for services and support. Of the 19 hospitals open in 1998, 11 had closed by the target date and the last closure was achieved in 2007 (Scottish Executive, 2004b; Trew, 2010).

Organization and provision

The number of adults with learning disabilities resident in long-stay hospitals has decreased substantially from over 1900 in 2001 to around 330 people in 2011 (a drop of over 80%). Over the same period the number in care homes has fallen by nearly a third from around 3100 in 2001 to around 2100 in 2010. In contrast, the number receiving home-care services has increased from nearly 1500 in 2001 to 4300 in 2011. Around 7800 adults with learning disabilities now live in their own tenancies, an increase of over 3500 since these data were first collected in 2003 (Scottish Government, 2012b).

This transformation in the pattern of service provision has had major implications for the NHS and local authorities. A fundamental theme arising from recent policy developments is the need for joint working arrangements between health and social work, and between primary and secondary care, with primary care increasingly in the lead. A few people, mainly those with forensic psychiatric needs, severe challenging behaviour or complex physical health care needs, continue to require long-stay care.

Access and quality

Over the last decade efforts have been made to improve access to services and to identify and prevent discrimination wherever possible. In particular, there has been focus on the recognition of each individual's rights and the promotion of positive attitudes. In support of this policy four landmark Acts have been enacted: the Adults with Incapacity Act (Scotland) 2000, Mental Health Care and Treatment Act (Scotland) 2003, Disability Discrimination Act (Scotland) 2005 and Adult Support and Protection Act (Scotland) 2007.

On access to general health care, NHS QIS developed a set of quality indicators for learning disabilities (NHS QIS, 2004a) and a best-practice statement: *Promoting access to health care for people with a learning disability – a guide for frontline NHS staff* (NHS QIS, 2006). However, a number of reports have highlighted the potentially tragic consequences of services failing to meet the health care needs of people with learning disabilities, and a review undertaken by NHS QIS, published in 2009 found a need for further progress on access, both scheduled and out of hours, on joined-up working and on staff awareness of the key legislation (NHS QIS, 2009).

5.8 Services for informal carers

Carers play a crucial role in the delivery of health and social care in Scotland. There are 657 300 identified carers in Scotland – 1 in 8 of the population – who are an essential part of the workforce, in its broadest sense, contributing savings to health and social care services in Scotland of an estimated £7.7 billion every year (Scottish Government, 2010d).

In recent years the contribution of carers has received greater recognition and support provided. Under the Community Care and Health (Scotland) Act 2002 boards were required to develop carer information strategies by 2007 to improve carer identification, information and training, with additional funding provided to support implementation of these strategies.

The Scottish Government issued a new strategy for carers in 2010 *Caring together: carers strategy for Scotland 2010–2015* (Scottish Government, 2010d), building on progress since the previous one published in 1999. Describing carers as "equal partners in the planning and delivery of care and support" it promised a Carers Rights Charter, improved uptake of carers' assessments and support plans, more training, funding to promote short breaks for respite, and carer representation on CHPs.

5.9 Palliative care

Palliative care is provided both by staff providing the day-to-day care to patients and carers in their homes and in hospitals (generalist care) and by those who specialize in palliative care (specialist care). Initially the development of palliative care was driven largely by the voluntary sector. Over the last 25 years government has taken a closer interest and a more strategic approach has been adopted and, while the voluntary sector remains very important especially in specialist palliative care, there is also growing NHS provision.

5.9.1 Organization and provision

Comprehensive information about palliative care has until recently been difficult to assemble. However, the Scottish Partnership for Palliative Care (SPPC) web site lists a total of 76 services – generalist and specialist – including 18 specialist palliative care units (of which two are children's units) in 10 board areas across Scotland (SPPC, 2012).

As far as GPs are concerned, one of the QOF indicators is having a palliative care register, which includes patients identified with palliative and end-of-life care needs irrespective of diagnosis, and requires that they are assessed and a care plan compiled within two weeks of inclusion, and assessed when they reach the last days of life to ensure they receive appropriate high-quality care. Such registers are in place in virtually all practices (96% in 2009/2010), although there is some doubt about their completeness (SPICe, 2010).

Hospices and NHS specialist palliative care units provide inpatient, day-care and home-care services staffed by a multidisciplinary team (including consultants in palliative medicine, and specialist nurses, social workers, pharmacists, physiotherapists and other professional staff) whose specialist training enables them to help people with more complex problems.

A recent survey found that 70% of inpatient activity and 72% of day-care places were in voluntary hospices (Audit Scotland, 2008). There are currently 15 voluntary hospices in Scotland providing care for patients at no charge. Since the 1990s NHS boards have been required to fund 50% of agreed annual running costs of the hospices in their area.

Increasingly, specialist palliative care is provided also within the NHS. There has been a steady increase in the number of palliative medicine beds in NHS hospitals (in 2010 only five boards did not have such beds) and, until recently, in the number of NHS doctors employed in the palliative medicine specialty (in all but the Island boards) (SPICe, 2010). In a number of NHS wards, specialist nursing support is provided by the voluntary sector though Macmillan Cancer Support.

5.9.2 Access and quality

Concern has been expressed about inequities in the provision of inpatient and day care geographically – there is no provision in four board areas – and in terms of diagnosis – 90% of specialist care is still delivered to patients with cancer (although cancer accounts for only 30% of all deaths). People with cancer living at home are also more likely to receive support from specialist nursing staff.

In 2002 the Clinical Standards Board for Scotland (CSBS) developed standards for specialist palliative care and its successor body, NHS QIS that carried out a review of services in 2004/2005 which found very high levels of performance in almost all hospices (CSBS, 2002a; NHS QIS, 2004b).

In recognition of the increasing number of people requiring palliative care in care homes, the SPPC and the Scottish Executive published in 2006 *Making good care better: national practice statements for general palliative care in adult care homes in Scotland* (SPPC, 2006) to clarify what was expected. The Care Commission's report *Better care every step of the way* (Care Commission, 2008) found significant scope for improvement.

5.9.3 Recent developments

Better health, better care (Scottish Government, 2007a) committed the Scottish Government to publishing a plan on how it would implement the recommendations of an earlier SPPC report that called for a comprehensive approach to the provision of palliative care across Scotland, including high-quality generalist palliative care in all care settings so that more people could "live and die well in the places they choose".

The Scottish Government's strategy, *Living and dying well: a national action plan for palliative care and end of life care in Scotland,* was published in 2008 (Scottish Government, 2008g). It was designed to ensure that "good palliative and end of life care is available for all patients and families who need it in a consistent, comprehensive, appropriate and equitable manner across all care settings in Scotland". At its heart was the decision to give patients who require palliative care more choice and control, notably by providing more care in the community and by recognizing the key role of GPs and the wider community team to plan, coordinate and deliver it. Annual funding of £3 million was announced to support implementation of the plan.

A National Advisory Group led by a National Clinical Lead for Palliative Care, has been appointed to support the implementation of the national plan and regular progress reports have been published.

5.10 Mental health care

Services for people with mental health problems have changed dramatically over the last 30 years, with the closure of large, long-stay hospitals and a focus on shifting resources and care into the community. For much of this time, mental health has been a national clinical priority (alongside CHD and cancer) and Scotland is recognized internationally for some of its work in this area, including mental health legislation. However, improvements in services and outcomes have proved more intractable than in the other clinical priorities.

Mental health problems vary significantly in their symptoms and severity. People with such problems therefore require a range of services that are provided by the NHS in hospitals and community settings; by local authorities through social work, education and housing services; and by voluntary and private organizations. The police and prison service also have an important role. There is a pressing need, therefore, for these agencies to work in partnership to deliver effective, joined-up services, and there is increasing emphasis on active involvement of users and carers in decisions about their care.

It is estimated that there are up to 850 000 people with mental health problems at any one time in Scotland, 16% of the population (Audit Scotland, 2009c). Only a small proportion (around 5%) have what are regarded as severe and enduring mental illnesses such as schizophrenia or bipolar disorder. The most common mental health problem is depression, affecting about 1 in 10 people at any one time (Action on Depression, 2011). Rates of suicide (often

associated with mental illness), at 14.7 per 100 000 population in 2010 (GROS, 2011a), are among the highest in western Europe and significantly higher than in England and Wales.

The Mental Health (Care and Treatment) (Scotland) Act 2003, implemented from 2005, made significant changes in the legislative framework under which mental health services operate, including strengthening the rights of those detained under the Act. It established a new Mental Health Tribunal as the principal forum for approving and reviewing compulsory measures for the detention, care and treatment of mentally disordered persons.

In 2006 a national mental health delivery plan, *Delivering for mental health* (Scottish Executive, 2006b) was produced, which included HEAT targets relating to reduction in the rate of prescribing anti-depressants, in the number of suicides and in the number of hospital re-admissions. These targets were supported by commitments to improve the range of services provided by the NHS and other agencies, including improved access to psychological therapies, piloting of peer support workers, development of standards for integrated care pathways, and improvements in services for specific groups, including children, people with dementia, people with mental health problems and substance misuse, and restricted patients.

A particular focus in recent years has been dementia, which the Scottish Government made an additional clinical priority in 2007, publishing a *National dementia strategy* in 2010 (Scottish Government, 2010k). A HEAT target on improvements in early diagnosis and management has been met; standards of care have been issued (Scottish Government, 2011m) and in 2012 Scotland led the way internationally by guaranteeing every person diagnosed with dementia a minimum of one year's post-diagnostic support from a named and appropriately trained person.

In tandem with improving services for people with mental health problems, steps have been taken to improve mental health and well-being. The most recent document, *Towards a mentally flourishing Scotland: policy and action plan 2009–11* (Scottish Government, 2009e) aims to promote good mental well-being, reduce the prevalence of common mental health problems, suicide and self-harm, and improve the quality of life of those experiencing mental health problems or mental illness.

5.10.1 Organization and provision

Mental health services are provided by a mixture of NHS, local authority, third sector and private sector providers. Boards, responsible for planning NHS provision, work in increasingly close partnership with local authorities through joint planning processes.

Inpatient care

Inpatient care is provided in general acute hospitals, psychiatric hospitals and separate purpose-built units providing care and support for people in periods of acute psychiatric illness. There are also psychiatric intensive care units for people compulsorily detained under the Mental Health Act.

In 1980 there were over 17 000 inpatient psychiatric beds in Scotland (general and old age psychiatry). By 2001 this number had fallen to just over 7500 beds and this trend has continued, albeit at a slower rate, so that by 2011 there were 4750 beds (Woods & Carter, 2003; Scottish Government, 2012b). Most inpatient care is provided by the NHS but there are a number of private psychiatric hospitals and clinics, focusing mainly on people with addictions.

In 2010/2011 there were around 20 919 inpatient admissions to mental health hospitals. This continues the downward trend seen in recent years and represents a 17% fall in the number of admissions since 2006/2007. Around 55% of these were re-admissions, a similar proportion to the previous five years. The most common diagnoses were alcohol/drug-related problems (25%), schizophrenia (19%) for men, and mood (affective) disorders (32%) and dementia (14%) for women. Around 65% had a hospital length of stay of four weeks or less, similar to previous years (ISD, 2011c).

Community mental health services

There is now a wide range of community mental health services provided by teams that include, in addition to nurses and psychiatrists, social workers, occupational therapists, psychologists and pharmacists. There has been a large increase in the number of mental health nurses working in the community. Since 2001, their numbers have increased from 700 to 1800 (Audit Scotland, 2009c), with a further 400 posts spanning hospital and community services.

A key part of community support is crisis and out-of-hours services. These can be provided solely or jointly by the NHS, councils and the voluntary sector. National standards were issued in 2006 to encourage the development of crisis response and crisis services across Scotland (Scottish Executive, 2006a).

A range of accommodation is also available to enable individuals to live more independent lives in the community. These include supported housing schemes, staffed or unstaffed group or care homes, short-term hostels and adult/family placement schemes. Respite care services are also available to give family carers time off from their caring responsibilities.

5.10.2 Access and quality

Mental health services are subject to close scrutiny due to the vulnerability of many of the people who use them. Particular concerns about standards in long-stay institutions led to the creation of an inspectorate, the Scottish Hospital (later Health) Advisory Service (SHAS), in 1970. Over the subsequent 32 years SHAS undertook inspection visits across Scotland, latterly based on a set of quality indicators (SHAS, 2002).

Complementing SHAS's work, the CSBS produced clinical standards for schizophrenia in 2001 and undertook a review of services against these standards, reporting in 2002 (CSBS, 2001, 2002b). The following year CSBS and SHAS came together as part of NHS QIS. Subsequently standards and/or guidelines have been produced for depression and anxiety, dementia, and attention deficit hyperactivity disorder.

Delivering for mental health included a commitment that NHS QIS would develop standards for integrated care pathways (ICPs) for schizophrenia, bipolar disorder, depression, dementia and personality disorder by the end of 2007 (Scottish Executive, 2006b). NHS boards were to develop and implement ICPs using these standards and these would be accredited from 2008 onwards. More recently standards have also been produced for child and adolescent mental health service ICPs.

The Mental Welfare Commission for Scotland is an independent statutory body that works to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. It investigates cases of alleged ill treatment or deficiency of care or treatment and visits people in a range of settings who are receiving care and treatment for mental disorder, some of whom will be subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000 (MWC, 2010).

Also responsible for inspecting mental health services were the Social Work Services Inspection Agency and the Care Commission, which merged to become the Social Work and Social Care Improvement Scotland (now known as the Care Inspectorate) in 2010.

5.10.3 Recent developments

Proposals for a new national mental health strategy, for the first time bringing together in a single document work to improve mental health services, to prevent mental illness and to promote mental health improvement were issued for consultation in September 2011 as *Mental health strategy for Scotland 2011–15* (Scottish Government, 2011d) The final strategy is due to be issued in 2012.

5.11 Dental care

As a result of concern about poor oral health in Scotland and about difficulties in accessing NHS dental services, particularly in certain parts of the country, the then Scottish Executive issued in 2005 an *Action plan for improving oral health and modernising NHS dental services* (Scottish Executive, 2005a). It set out a number of ambitious commitments to overhaul and strengthen NHS dentistry services and improve dental public health, including a range of targets.

To support this programme a substantial increase in funding (almost £300 million over three years) was promised and, to be eligible for additional funding, independent general dental practitioners had to demonstrate "NHS commitment", providing a service to all categories of patients (not just to children, for example), and with a significant proportion of their work being for NHS patients. NHS boards were also given authority to appoint directly salaried General Dental Service (GDS) dentists.

The SNP government maintained and extended this direction of travel, highlighting the importance of children's oral health and extending the Childsmile programme to apply fluoride varnish to children's teeth at school.

There are no artificial fluoridation schemes in operation and only Moray in north-east Scotland receives naturally fluoridated water.

At the other end of the age spectrum the Scottish Government has recognized that older people face more constraints on health and mobility, which can make attending the dentist more difficult. Caring for Smiles is an initiative to assist oral health professionals to deliver training for staff in care homes.

5.11.1 Organization and provision

There are three types of dental service:

- general dental services, offering registered patients the full range of NHS treatments provided by independent contractors working on behalf of local NHS boards;
- community dental services, providing care in clinics, nursing homes, etc. for patients who would find it difficult to use general dental services, and responsible for screening schoolchildren for dental decay and delivering oral health promotion;
- secondary and tertiary dental services in acute hospitals and in specialist dental hospitals providing treatment for more difficult or complex problems.

General dental services are provided by both the NHS and the private sector. Many dental practitioners provide both NHS and private dental care from the same premises and sometimes to the same patient. There are very few wholly NHS or wholly private practices. Hospital and community dentists are NHS employees.

NHS boards are responsible for planning and provision of NHS dental services in their area. In practice this is one of the responsibilities of CHPs.

Hospital dental services treat patients in outpatient clinics and as inpatients or day cases in Scotland's two dental hospitals (Glasgow and Dundee) and the Edinburgh Dental Institute or in many general hospitals. The most common reason for hospital treatment is extraction of multiple teeth (40% of all elective admissions, 60% of which are for patients living in the most deprived areas of Scotland) (ISD, 2011h).

Over the last 20 years there has been a significant decrease in the number of children treated by community dental services, reflecting the policy of encouraging children to visit a general dental practitioner. The number of adults using the community dental services increased temporarily, due to the difficulty in parts of the country in accessing NHS general dental practitioners, but has now returned to its previous level (ISD, 2007).

In 2011 there were 3466 dentists working in Scotland; 2674 were non-salaried general dental practitioners working in around 950 practices, 407 salaried general dental practitioners, 489 community dentists and 415 hospital dentists (excluding specialists in oral and maxillofacial surgery) (ISD, 2011k)

the numbers exceed the total as some dentists work in more than one service. General dental practitioners decide where to locate their practices and how much NHS treatment to provide.

5.11.2 Access and quality

Access to NHS dental care is determined both by the availability of NHS dentists and by ability – and willingness – to pay the charges for NHS treatment. In recent years there has been concern that patients, especially in certain parts of the country, were experiencing difficulty in accessing NHS dentistry as dentists reduced their commitment to the NHS and developed their private practice work, partly in protest at the level of fees set by the Scottish Government. In response, the Scottish Government has increased recruitment to dental schools (leading to an increase of almost a third in the number of general dental practitioners since 2002) and encouraged boards to employ salaried dentists, whose numbers increased sixfold from 67 in 2002 to 407 in 2011 (ISD, 2011k; see also Scottish Government, 2010a).

In 2011, 76% of the population was registered with an NHS GDS dentist (76% adults and 86% children including almost 98% of 6–12 year olds). The rate of participation (those registered who have attended for treatment in the past two years) was 79% for adults and 88% for children (ISD, 2011e).

In 2005 additional funding was made available to NHS boards to provide out-of-hours emergency dental services in a more integrated manner. The Scottish Emergency Dental Service (SEDS) was implemented throughout the NHS during 2009.

There are a number of statutory and regulatory bodies which monitor aspects of NHS and/or private dentistry in Scotland. This includes monitoring quality of dental treatment, educational provision for newly qualified dentists and quality of dental practices.

- The GDC registers all United Kingdom dentists, dental nurses and other dental professional staff, and investigates misconduct. It is developing a revalidation process similar to that for doctors, which is due to be implemented in 2014.
- The Scottish Government requires boards to undertake regular inspections of NHS practices using a template that focuses on premises and equipment, and on areas such as health and safety and infection control.

- Practitioner Services (PSD) of NSS conducts audits to ensure that public money is being used appropriately, including random patient examinations to check treatment was necessary and completed to a satisfactory standard.
- NES inspects NHS dental practices for vocational training or general professional training.

A number of dental practices also choose to become involved in voluntary accreditation schemes, such as the British Dental Association (BDA) Good Practice Scheme or Investors in People Award. In 2012 the BDA reported 86 practices as members of the Scheme and around 500 working towards membership (BDA, 2012).

In addition, the Regulation of Care (Scotland) Act 2001 made provision for inspection of private dental care and conferred powers on the Care Commission. In preparation for bringing these provisions into force *National standards for dental services,* developed by the National Care Standards Committee (on behalf of the Scottish Government) and NHS QIS were issued in 2006 (Scottish Executive, 2006d). In 2010 the powers to regulate and inspect private dental practice were transferred from the Care Commission to NHS QIS's successor body, HIS, but they have still to be commenced.

Standards on out-of-hours emergency dental services were produced in 2007. These were used by NHS QIS to undertake a review resulting in publication of *Out-of-hours emergency dental services* in 2010 (NHS QIS, 2010).

In terms of outcomes, the target of 60% of children in the first year at primary school to be free of dental decay by 2010 has been achieved. The latest National Dental Inspection Programme report shows that 64% of Primary 1 children were free of dental decay, in comparison with about 40% 20 years ago (SDECC, 2010). However, the majority of dental disease continues to be in children from more deprived backgrounds with only 45% of Primary 1 children in the most deprived tenth of the population having no obvious decay compared to 81.5% of those in the most affluent. This is being addressed through the Childsmile programme, with 90 274 children having fluoride varnishing in 2010/2011.

6. Principal health reforms

For the first few years after the election of a (United Kingdom) Labour government in 1997, broadly similar steps were taken in Scotland and England to dismantle the internal market that had been developed by the previous Conservative government. From 2000, however, the Labour/Liberal Democrat coalition in Scotland began to pursue an increasingly distinctive approach that stressed integration and partnership among all parts of the NHS, eschewing moves in England to revert to a market in health care delivery (particularly for elective care) involving both NHS and private sector providers. The election of a SNP government in 2007 reaffirmed this policy and emphasized the continuation of a publicly provided service with a new focus on mutuality – involving patients and the public and NHS staff as "owners" and partners rather than just users and providers – and on quality as the driver of modernization and improvement.

6.1 Analysis of recent reforms

Major policy statements and reforms are described in this section and are highlighted in Box 6.1.

Box 6.1

Major policy statements and reforms, 1997–2011

	NHS reforms	Related developments
1997	Publication of *Designed to care: renewing the NHS in Scotland*	Election of United Kingdom Labour government
1998	Publication of report of Acute Services Review	
1999	Health Act	Election of first Scottish Parliament leading to formation of Labour/Liberal Democrat coalition
2000	Publication of *Our national health: a plan for action, a plan for change* and *Community care: a joint future*	
2001	Publication of *Patient focus and public involvement*	
2002		Community Care and Health (Scotland) Act
2003	Publication of *Partnership for care: Scotland's health White Paper*	Re-election of Labour/Liberal Democrat coalition
2004	NHS Reform (Scotland) Act	
2005	Publication of *Delivering for health* in response to *A national framework for service change in the NHS in Scotland: building a health service fit for the future*	
2006		
2007	Publication of *Better health, better care action plan* Launch of Scottish Patient Safety Programme	Election of minority SNP government
2008	Launch of *Better Together* (patient experience programme)	
2009	Health Boards Direct Elections (Scotland) Act	
2010	Publication of *The healthcare quality strategy for NHSScotland*	
2011	Patient Rights (Scotland) Act	Election of majority SNP government. Publication of report of (Christie) Commission on the Future Delivery of Public Services

6.1.1 Dismantling the internal market

The Scottish Labour manifesto for the 1997 United Kingdom general election promised early action to abolish the internal market that had been established, albeit rather hesitantly in Scotland, by the Conservatives. In December 1997 in the same week that the Department of Health in England produced *The new NHS: modern, dependable* (Department of Health, 1997), the Scottish Office published its own health White Paper, *Designed to care: renewing the NHS in*

Scotland (Scottish Office, 1997). There were many similarities between the two documents, including the promotion of partnership working and service integration, a concern with the quality of clinical practice, a commitment to improve access to care through reductions in waiting times and a determination to tackle health inequalities, but in Scotland a rather different organizational model was presented.

This retained separate roles for health boards and NHS trusts, strategy/planning and operational management, respectively. Trusts, previously competitors, were to be amalgamated into just two types: acute (usually one per board) and primary care (again, normally serving whole board areas). This for the first time brought together primary care, community health services, and specialist services for older people and people with mental illness and learning disabilities.

GP fundholding was abolished and, to promote greater integration of care and a community focus, voluntary combinations of GPs were encouraged to form local health care cooperatives, accountable to primary care trusts. Various mechanisms were put in place to encourage the concept of "local health systems", comprising boards and trusts, including chairs of trusts serving as non-executive directors of boards, and to promote the integration of primary and secondary care through joint working between acute and primary care trusts. Under the new arrangements, boards continued to be accountable to the Scottish Government but trusts were accountable to boards.

To the extent that these changes required legislation, these were enacted in the (United Kingdom) Health Act 1999. This also conferred on boards a "duty of quality" to underpin the new clinical governance arrangements that were being put in place (see section 2.7).

Overall the aim of the White Paper was to develop "a partnership between different parts of the NHS in Scotland to promote the integration of care and provide patients with a seamless service". These ideas were developed further in an acute services review, initiated by the Chief Medical Officer and published in 1998 (Scottish Office, 1998a). The review was concerned with equity of access, quality of services and outcomes, optimal use of resources, networking, emergency pressures, service redesign and responsiveness, and clinical effectiveness. Its proposals led to the creation of the CSBS, to the Remote and Rural Areas Resource Initiative, to a raft of service redesign projects, and to the development of managed clinical networks, which it defined as "linked groups of health professionals and organizations from primary, secondary and tertiary

care, working in a co-ordinated manner, unconstrained by existing professional and health board boundaries" (see Curry and Ham, 2010 for a summary of the impact of these networks).

In 1999, under the terms of the Scotland Act 1998, responsibility for health was devolved to the Scottish Parliament and the Scottish Executive (see Chapter 1). Under the new funding arrangements Scotland benefited from the United Kingdom Government's decision to increase health spending to the "European average" (for a description of this system see Chapter 3) and a "modernization" plan for the NHS *Our national health: a plan for action, a plan for change* was produced (Scottish Executive, 2000c).

The Scottish plan emphasized public health and announced a "rewiring" of NHSScotland (a new brand name). Boards and trusts were retained but brought together in "unified boards of governance". The membership of these NHS boards (another new term at the time) included people appointed by ministers from local authorities and NHS staff representatives. The aim was "to simplify, improve and rationalize the current local decision-making arrangements" without embarking on another restructuring of the NHS. However the plan announced "a high-level review of the management and decision-making in the NHS" leading to the publication of a further White Paper *Partnership for care: Scotland's health White Paper* in 2003 (Scottish Executive, 2003).

One area on which early action was taken was the development of partnership arrangements with NHS staff (see section 4.2.3). These have become embedded to the extent that a recent independent evaluation concluded that, although partnership agreements now cover approximately one-third of all public sector employees in Britain, the arrangements in NHSScotland have "matured into probably the most ambitious and important contemporary innovation in British public sector relations" (Bacon & Samuel, 2012).

6.1.2 Integration and collaboration

The proposals in *Partnership for care* represented a step change in terms of divergence from England. They were designed "to support the development of integrated, decentralized services that meet the needs of individual patients and local communities". The process of dissolving trusts had already started in the two smallest mainland boards and the White Paper announced that the remainder would be abolished and legislation enacted to remove the powers relating to NHS trusts.

Boards were to develop their own plans to "strengthen corporate working and provide clear strategic direction [that does not] result in greater central control over operational matters". This was to be achieved by requiring boards to put in place effective arrangements that devolved operational responsibility to frontline staff, and by a strengthened national system of monitoring and inspection, designed to give the centre early warning of problems without reintroducing the "command and control" culture of the 1970s and 1980s.

Within this general framework three ideas were emphasized. First, the development of managed clinical networks was to be accelerated and boards were to form regional groupings to take this forward. Second, new organizations – CHPs – were to evolve from the network of local health care cooperatives into operating divisions of NHS boards charged with the management and development of integrated primary care, community health and social care services. CHPs were to have a key role in accelerating progress in delivering the approach advocated in the Joint Future Group's report, *Community care: a joint future,* designed to promote more effective joint working between the NHS and local authorities through joint management and resourcing, single shared assessment, and improving the balance of care for older people (Scottish Executive, 2000a). This approach was underpinned by the Community Care and Health (Scotland) Act 2002, which introduced new powers, including the potential to transfer functions and resources and to pool budgets. Third, there was a commitment to development of a more corporate national approach to shared services, including IM&T, finance, procurement, estates and human resources, not through the creation of new central organizations but through cooperative working among boards and other public organizations.

These proposals were enacted by the NHS Reform (Scotland) Act 2004 and the new integrated structure was in place, with the abolition of the last trusts, by April 2004. The Act also conferred upon boards a duty of staff governance, akin to that of clinical governance in the 1998 Act, underpinning the commitment to working in partnership with staff at all levels in the NHS.

Despite the significant increases in funding, the NHS faced similar funding pressures to its counterpart in England, leading to attempts by boards to centralize services. Unfavourable cross-border comparisons were also made about performance, particularly on waiting times. This prompted two developments.

First, a National Advisory Group on Service Change published a report, *Building a health service fit for the future,* in 2005, following wide consultation, setting out its vision of the NHS: safe, high-quality services that are as local as possible and as specialized as necessary (Scottish Executive, 2005b). In his foreword, its Chair, Professor David Kerr, wrote:

> At risk of seeming overly sentimental, I believe that a more truly Scottish model of health care would be to take a collective approach in which we generate strength from integration and transformation through unity of purpose. Patient choice is important, but the people of Scotland sent us a strong message that certainty carries greater weight – if we make a commitment to see or treat a patient on a specific date, we must honour this, and ensure the quality of care delivered.

The Scottish Executive's response, *Delivering for health,* generally endorsed the conclusions and recommendations of the National Advisory Group (Scottish Executive, 2005d). It set out a programme of action designed to shift the balance of care away from episodic, acute care in hospitals, increasingly through emergency admissions, to a system that emphasizes preventive medicine, support for self-care, and greater targeting of resources on those at greatest risk through anticipatory medicine. The Scottish Executive committed itself to delivering its plans "through the continuing development of the NHS as an integrated service". The emphasis on integrating care required multidisciplinary team working and "collaboration and co-ordination between professionals and across organizational boundaries – in fact, a partnership approach at all levels to achieve continual improvements in quality and value for money".

Second, following a change in minister, a tougher and more sophisticated approach to performance management was introduced. A new delivery group was established within the Health Department to ensure a sharp focus on delivery of key priorities and targets, drawing together and strengthening the performance management function by agreeing annual local delivery plans with each board, providing systematic monitoring of performance – through what became known as the HEAT system (see section 2.5) – and playing a more assertive role in supporting and, where necessary, intervening.

6.1.3 Mutuality

The minority SNP government, elected in 2007, maintained the structure established by the previous administration. Its strategy document *Better health, better care* was built around what it described as "the existing strengths of NHSScotland – a collaborative, integrated approach built upon our traditional values" (Scottish Government, 2007a). It committed the Scottish Government to:

> retain our unified Board structure and ensure that NHSScotland remains firmly in the public sector – a public service delivered in partnership with the public. Our Action Plan brings together our commitments to public participation, improving patient experience, patient rights and enhanced local democracy and expresses them in terms of a more mutual approach to healthcare. The Scottish people are more than consumers of NHS services. They share ownership of the NHS and that gives them rights and responsibilities …

Ensuring that NHSScotland is based on a mutual ethos was not considered to involve any changes in its overall structure or financial arrangements on the grounds that "it is entirely consistent with our existing approach of integrated care, based on the values of co-operation and collaboration delivered through unified Boards" (Scottish Government, 2007a). This was heralded as a more effective means of driving change than internal competition and market forces. Nonetheless the Scottish Government recognized the need for:

> new ways of thinking about health and health care. We need to move, over time, to a more inclusive relationship with the Scottish people; a relationship where patients and the public are affirmed as partners rather than recipients of care. We need to move towards an NHS that is truly publicly owned. We need to move towards an NHS where ownership and accountability is shared with the Scottish people and with the staff of the NHS. We need to move towards an NHS where we think of the people of Scotland not just as consumers – with only rights – but as owners – with both rights and responsibilities.

To this end, the action plan contained proposals to:

- strengthen patient and public involvement in the NHS;
- link performance targets to long-term strategy and with other approaches across the public sector;
- strengthen partnership working with NHS staff and with voluntary and community organizations;
- strengthen clinical leadership, for example in expanding the coverage of managed clinical networks;
- improve quality across all six dimensions of quality identified by the (US) Institute of Medicine: person-centred, safe, effective, efficient, equitable and timely (Institute of Medicine, 2011).

The overarching concept of mutuality was an innovation but in other respects the action plan confirmed and extended the direction of travel set by its predecessors since devolution. It also confirmed the diverging paths of the NHS in Scotland and England in its rejection of solutions based on market forces or internal competition. In a similar vein, the Scottish Government announced

that it would be developing a replacement for the PPP/PFI approach to capital investment developed by its predecessor (see section 4.1.1 *Capital stock and investment,* sub-section on *Investment funding*).

The approach to the NHS was consistent with the Scottish Government's approach to the public sector generally. To articulate a distinctive Scottish approach in response to rising demand for public services in an environment of constrained public spending, the Scottish Government established in 2010 a Commission on the Future Delivery of Public Services. Its report, published in July 2011, called for substantial reform of how public services are delivered to make them "outcome-focussed, integrated and collaborative. They must become transparent, community-driven and designed around users' needs. They should focus on prevention and early intervention." (Scottish Government, 2011h). The Commission identified four key objectives to shape a programme of reform and to ensure that:

- public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience;
- public service organizations work together effectively to achieve outcomes;
- public service organizations prioritize prevention, reducing inequalities and promoting equality; and
- all public services constantly seek to improve performance and reduce costs, and are open, transparent and accountable.

6.1.4 Quality strategy

Over the four years since publication of *Better health, better care,* action has been taken to implement most of its proposals. In addition, the commitment to enhance the quality of health care was further developed in *The healthcare quality strategy for NHSScotland,* published in May 2010 (Scottish Government, 2010m). Building upon the achievements in relation to waiting times and patient safety, and reinforcing the commitment to a mutual NHS, the strategy was built around the three quality ambitions (see section 2.5) and committed the NHS to six priorities:

- *caring* and *compassionate* staff and services
- clear *communication* and explanation about conditions and treatment
- effective *collaboration* between clinicians, patients and others

- a *clean* and safe care environment
- *continuity* of care, and
- *clinical* excellence.

Implementation of the quality strategy was seen as the means by which longer-term transformational challenges are addressed and, in the shorter term, greater efficiency and productivity achieved. As well as building upon existing initiatives, the strategy recognized the need "to do some new things and to do some things differently", but within the context of "NHSScotland's integrated delivery arrangements, encouraging whole system improvement through mutually beneficial partnerships between clinical teams and the people in their care" and in partnership with other bodies. To this end, it has provided the context for all subsequent statements of Scottish Government policy on different aspects of health care.

6.2 Conclusion and future developments

The election of a majority SNP government in 2011 did not herald any change in direction as far as the NHS is concerned. Its manifesto stated that "the SNP remains 100% committed to the Scottish NHS as a publicly-funded and publicly-delivered service" and promised to protect the health budget in real terms and to maintain the direction of travel it had set over the previous four years, based on integration and partnership – inherited from its predecessor – and on implementation of the quality strategy (SNP, 2011).

During the prolonged debates in 2011/2012 in Westminster over the coalition government's Health and Social Care Bill the contrast in approach north and south of the border attracted considerable attention. In Scotland there was widespread relief that none of the changes being extended in England would apply in Scotland, including purchaser–provider separation, foundation trusts, competition among NHS providers or with the private sector with patient choice as a driver of change, or activity-based payment of hospitals. Instead in Scotland an NHS firmly within the public sector would maintain and strengthen:

- integration of planning and delivery functions but with a high degree of operational delegation;
- accountability of all parts of the NHS through NHS boards to the Scottish Government and Parliament;

- cooperation and collaboration among all parts of the NHS and with other organizations;
- partnership with staff and with patients and carers;
- and a focused performance management system designed to ensure that the NHS delivers its health improvement, health care and financial targets.

NHSScotland faces the same challenges as its counterparts in the rest of the United Kingdom: the increased burden of disease associated with an ageing population, the added costs of technological advances and constrained funding. Its response is seen not as a "head in the sand" adherence to old ways of doing things but as a distinctive and well-founded approach that will enable it to rise to these challenges while preserving the fundamental principles of the NHS and avoiding the risks and transaction costs associated with the reforms being implemented in England.

7. Assessment of the health system

For the last 25 or so years, there has been a striking consistency in the objectives of successive Scottish governments regarding the health system: improving population health; improving the quality and outcomes of health care, and improving the efficiency and productivity of spending on health. Coupled with a relative lack of organizational turbulence, this stability in aims has provided a strong launching pad for achieving beneficial change. Progress has been made in relation to each of these aims. Health status has improved significantly, although a gap still persists between Scotland and other countries and among socioeconomic groups in Scotland. Scotland has led the way in taking forward many aspects of the quality agenda, with encouraging results such as a reduction of over 9% in hospital standardized mortality ratios and evidence in specific indicators for each of the "standard" dimensions of health care quality: person-centred, safe, effective, efficient, equitable and timely. There have also been improvements in all the main indicators of allocative and technical efficiency, and financial balance has been maintained at the same time as these improvements have been achieved. Comprehensive and rigorous analysis of the performance in the health system, including comparison with performance in other countries, lies beyond the scope of this report. Various attempts have been made to do this (for example Sutherland & Coyle, 2009; Nuffield Trust, 2010; CPPR, 2010), but many of their conclusions have been challenged, not least due to the lack of comparable data of high quality.

7.1 Stated objectives of the health system

Although the precise wording and the relative emphasis may have changed, each of the strategic documents produced over the last 25 or so years has set out three key objectives for the health system:

- improving the health of the people of Scotland, to counter Scotland's reputation as the "sick man" of Europe and to address the problem of inequalities in health;
- improving the quality and outcomes of health care, with a strong focus on access but increasingly on all the dimensions of quality as defined by the (US) Institute of Medicine: person-centred, safe, effective, efficient, equitable and timely (Institute of Medicine, 2001);
- improving the efficiency and productivity of spending on health so as to achieve more health gain for each pound spent.

For example, the strategic framework produced in 1990 following the then Conservative government's Working for Patients White Paper (Scottish Office, 1989) had as headlines "Improving Health" and Improving Care" (Scottish Office, 1991a). These themes continued through the period of Labour/Liberal Democrat coalition and, most recently, they have been articulated in almost identical terms in the current strategic documents produced by the SNP government. *Better health, better care* (Scottish Government, 2007a) set out the Scottish Government's plans to achieve its strategic purpose of a healthier Scotland by developing a mutual NHS, by helping people to sustain and improve their health, particularly in disadvantaged communities, and by ensuring better, local and faster access to health care. Specifically for the NHS, *The healthcare quality strategy* (Scottish Government, 2010m) had as its ultimate aim delivery of "the highest quality health care services … and through this to ensure that NHSScotland is recognized … as amongst the best in the world".

Following the 2011 election the Scottish Government defined its objectives for 2012/2013 onwards as:

- to continue to protect the most vulnerable people in our society through early intervention, by ensuring our children get the best start in life and by promoting equality;
- to achieve sustainable, world-leading quality in health care, ensuring that people are able to be in their own homes and communities when possible and appropriate, and that they have a safe and good experience of health care services; and
- to maximize value by supporting the people delivering health and care service and through increased efficiency (Scottish Government, 2011k).

Since 2006/2007 these goals have been reflected in the HEAT targets that are at the core of the NHS performance management system, which are now incorporated in the overall national objectives set by the Scottish Government and reported as part of the Scotland Performs arrangements. The Scottish Government has also sought to strengthen cross-government intersectoral working structurally and financially.

The objectives are shared across a wide political spectrum embracing all three political parties that have been in government since 1999 (Labour, Liberal Democrat and SNP). Moreover, while some in the Conservative Party are sympathetic to the market approaches being pursued in England as a means of promoting greater health care efficiency, and place greater emphasis on personal responsibility rather than state intervention in relation to health, there is near unanimity of political support for the aims of health policy and for preserving the distinctive character of the health system in Scotland. Even during the 1990s the development of the internal market was pursued much more cautiously in Scotland than in England, and since devolution all parties have been committed to a collaborative, integrated approach based upon partnership among NHS organizations, between the NHS and other bodies affecting health, and with patients and staff.

7.2 Financial protection and equity in financing

7.2.1 Financial protection

Financial protection – the extent to which people are protected from the financial consequences of illness – is strong in a system in which almost all health care services are funded through general taxation and provided free at the point of use. However, while user charges (for some aspects of NHS dental and ophthalmic care) are trivial in terms of the overall costs of health care, the deterrent effect of these charges was a major factor in the decision to introduce free eye tests for everyone in 2006 and to abolish prescription charges in 2011.

A much more serious issue – for individuals and the Scottish Government – is the cost of care of older people. Following publication of the Sutherland Report in 1999 (Sutherland, 1999), Scotland (alone in the United Kingdom) decided to introduce free personal assistance with such things as personal hygiene, eating and drinking, and mobility, as well as nursing care for those people aged 65+ assessed by their local authority as needing it. Nonetheless the assessment process and the bureaucracy associated with it create anxiety

and it has not dispelled all fear about the costs of old age, particularly for those who require residential care for which individuals are required to pay all the care home fees (less any entitlement to free personal and/or nursing care) if they have savings and capital in excess of £23 500 in 2011 (Age Scotland, 2011). The escalating cost of the "free personal care" policy is also an issue of political debate.

The universality and comprehensiveness of the NHS are reflected in the low uptake of VHI in Scotland. Those who opt for this do so mainly on grounds of choice: to obtain speedier access to elective procedures, to have greater choice of consultant and over the timing of treatment, and to benefit from a private room and other "hotel" facilities provided in the private sector. These relative benefits have become less significant, however, as NHS waiting times have fallen and patients have been able to exercise greater choice within the NHS.

7.2.2 Equity in financing

The NHS is funded mainly through general taxation and through the NHS element of NICs (in effect another form of general taxation). The funding of the NHS is therefore equitable to the extent that the system of taxation is progressive. A study of 12 OECD countries concluded that overall the system in the United Kingdom is "mildly progressive" and in this respect Scotland is no different from other parts of the country (Wagstaff et al., 1999).

7.3 User experience and equity of access to health care

7.3.1 User experience

Surveys of user experience are important as a measure of quality and as a signpost to areas for action to improve quality. The Better Together programme was launched in 2008 to provide reliable patient feedback on a consistent and systematic basis, focusing initially on GP services and inpatients. Its surveys have confirmed earlier evidence of high levels of patient satisfaction. Of those who responded to the most recent GP survey, 89% rated the overall care provided by their GP surgery as good or excellent; only 2% felt it was poor or very poor (Better Together, 2012) . Most patients (85%) who responded to the inpatient survey also rated their overall care and treatment as good or excellent, while 4% rated it as poor or very poor. Of the various stages in the inpatient journey, patients were most positive about staff and least positive about discharge arrangements.

Comparison with experience in other countries is far from easy due to differences in the topics covered, the wording of questions and in the way results are calculated (e.g. whether they are weighted according to population). Attempts to draw comparisons between Scotland and England, in the Better Together reports and in independent analyses, have concluded that the results both for GP services and for inpatient hospital services are very similar (CPPR, 2010).

Survey results are supplemented by other means of gauging patient experience. The number of complaints received (less than 0.1% of the total number of patient contacts) is a poor measure as many people are reluctant to lodge a formal complaint and an increasing number of complaints may reflect greater efforts to encourage them. However, they do provide a picture of areas of greatest concern to patients and their relatives. Successive analyses of complaints and the reports of the Ombudsman have highlighted persistent problems about communication with patients and their relatives and about the dignity and respect with which patients, particularly those who are older or vulnerable, are treated (SPSO, 2012).

7.3.2 Equity of access to health care

Universal access to health care and a national health care system, have contributed to greater equity both in terms of socioeconomic status and geography, but they have not eliminated inequalities. Indeed, there is increasing concern about the limited progress that has been made in addressing inequalities in access, for example to primary care.

Another equity issue in Scotland relates to geography. There is some overlap with socioeconomic inequality as some of the most remote areas of the country also have pockets of socioeconomic deprivation. Ensuring that all people have good access to health care regardless of where they live was a major factor behind the setting up in 2004 of the Kerr Committee, which established a remote and rural workstream leading to publication of a sustainable model of remote and rural health care in 2008 (Scottish Government, 2008c). Significant progress has been made, for example in telehealth, in community hospitals and in more flexible deployment of staff, but any change in the pattern of service provision, driven by safety or staffing considerations, gives rise to considerable controversy in local communities.

Coverage of the NHS is comprehensive; however certain treatments are not available. Particularly controversial in recent years has been access to expensive medicines, particularly for the treatment of cancer, which have

been assessed by the SMC as not being clinically effective and cost-effective. Boards have systems in place to review individual requests for such medicines from any clinician who thinks that its use is appropriate for a particular patient (HRIS, 2010).

7.4 Health outcomes, health service outcomes and quality of care

7.4.1. Population health

There is evidence of improvement in population health in recent years but gaps persist (see Chapter 1). For example, despite the increase in HLE between 1999 and 2008 by about 3 years for men and 2 years for women, it remained around 3 years lower than the United Kingdom average for men and 1.5 for women. Figures for overall life expectancy paint a similar picture: while it has increased in Scotland, it remains lower than the rest of the United Kingdom and most other western European countries. Recent research has shown that, while de-industrialization and socioeconomic characteristics are important, there are other as yet unexplained factors that account for poorer health outcomes in Scotland than in other parts of the United Kingdom with similar history and socioeconomic profile (Taulbut et al., 2011).

Data for the three biggest causes of premature mortality in Scotland – CHD, stroke and cancer – show a continuing downward trend, most markedly for CHD and CVD (mainly stroke):

- 40% reduction in age–sex-standardized mortality rates from CHD between 2001 and 2010 (with just over 60% reduction among under 75s between 1995 and 2010 thus achieving the Scottish Government's target) (ISD, 2011g);
- 59% reduction in age-standardized mortality rates from CVD among under 75s between 1995 and 2010 (also achieving the Scottish Government target) (ISD, 2011t);
- a reduction of almost 12% in age-standardized cancer mortality rates between 2000 and 2010, despite an increase of 2.4% in the actual number of deaths due to cancer, reflecting the fact that cancer is more common among older people and the number of older people is growing (ISD, 2011c).

The NHS has made a significant contribution to these trends through its preventive services, through screening and other measures leading to earlier diagnosis, and through advances in treatment. This is reflected in improvements in survival rates. For example five-year survival for cancer patients, relative to the life expectancy of the population in general, increased from 26% for males diagnosed in 1983/1987 to 44% for those diagnosed in 2003/2007, and from 36% to 51% for females (Scottish Government, 2011c).

Concerted action is also being taken to address the risk factors that cause ill-health and premature mortality, reflecting cross-party and continuing endorsement in Scotland of the efficacy of government action to control and restrict activities that contribute to poor health. High priority has been given to action to reduce smoking and there is evidence that this is having an effect. Smoking in adults decreased gradually from 30.7% in 1999 to 24.2% in 2010 (but this was still higher than the Scottish Government target of 22%), and in 2010/2011 there were 90 000 successful quit attempts made with the help of NHS smoking cessation services, exceeding the target of 84 000 (Audit Scotland, 2011c).

Scotland was the first country in the United Kingdom to implement a ban on smoking in public places. Early attempts to gauge the impact of the ban have found that hospital admissions due to childhood asthma fell by 18% following the ban, compared with a 5% annual reduction in the years before the ban (Audit Scotland, 2011c); and there was a 17% reduction in admissions for acute coronary syndrome in the 10 months following the ban, significantly greater than the mean decrease in the previous decade (Pell et al., 2008). Further restrictions have also been placed on the sale of tobacco products. Nonetheless, smoking remains a major challenge. In 2010 there were still over 1 million adult smokers (25% of the adult population) and as rates of smoking in men have declined, the rate in women has increased. Smoking-related deaths still account for about a quarter of total deaths each year (Audit Scotland, 2011c).

The position regarding alcohol and obesity is even more challenging. The number of alcohol-related deaths in 2010 was about the same as in 2000 but twice as high as in 1990; levels of alcohol-related hospital admissions increased by over a third between 1997 and 2008 but fell back in the two subsequent years. Similarly, between 1989 and 2009 there was a threefold increase in the number of men diagnosed with chronic liver disease and a twofold increase among women, but both figures decreased slightly in 2010 (Audit Scotland, 2011c). The death rate from cancer of the liver has increased by 48% in men over the last decade (Scottish Government, 2011c). In 2011 multi-buy discounted

selling of alcohol was banned but an attempt to introduce a minimum unit price was defeated. In 2012, however, this further step was agreed in principle by Parliament.

On obesity, Scotland has one of the highest levels in the world, exceeded only by the USA and Mexico among OECD countries. In 2010 almost two-thirds of men aged 16–64 and more than half of women were classified as overweight, obese or morbidly obese. Both figures were more than 10% higher than in 1995 and obesity levels are predicted to increase by more than 50% by 2030 in comparison with 2008 (Audit Scotland, 2011c). In 2010, only 22% of adults met the recommended daily intake of five or more portions of fruit and vegetables, and only 39% of adults met the recommended level of at least 30 minutes moderate activity on at least five days of the week (Scottish Government, 2011c).

7.4.2 Health service outcomes and quality of care

Scotland has led the way in the United Kingdom in taking forward the quality agenda. It has in many respects pioneered the development of clinical audit, clinical guidelines, clinical outcome indicators, clinical standards and their use as the basis of reviewing clinical performance. None of these developments is unique to Scotland but they have been taken forward in a distinctive manner, with an emphasis on clinical leadership and ownership while working in partnership with government and NHS management (Woods & Carter, 2003).

These initiatives are only worthwhile, however, if they result in improved standards of care and better outcomes for patients. Measuring quality and attributing causality are complex processes. A composite proxy that is now widely used although not universally accepted is the hospital standardized mortality ratio. Against a baseline of 2006/2007 these had decreased by around 9.5% by early 2012, with some hospitals achieving reductions of up to 19% (ISD, 2012b).

Two areas of particular public concern have been waiting times and health care-associated infections. Waiting times have fallen progressively over the last decade. In 2010/2011:

- the existing waiting times standards were delivered: with no patient waiting more than 12 weeks for the first outpatient appointment; more than 9 weeks for inpatient/day-case surgery; or more than 6 weeks for one of 8 key diagnostic tests;

- good progress was made in delivering the 18 weeks referral (from all sources) to treatment target (RTT), with 85% patients in March 2011 being treated within this timescale;
- performance against the standard of 98% of patients being seen at A&E within four hours ranged between 94% and 96%;
- 94% of patients had contact with an appropriate primary health care professional within 48 hours against a target of 90% (Scottish Government, 2011f).

Comparison with other parts of the United Kingdom is difficult because of differences in the way waiting times data are collected. But data published on behalf of the United Kingdom Comparative Waiting Times Group showed that Scotland had the lowest median waiting time for 7 of the 11 procedures that are tracked (ONS, 2010).

Against its targets of reducing all *Staphylococcous aureus* bacteraemia (including MRSA) cases by 41% between 2005/2006 and 2010/2011 and *Clostridium difficile* infections in patients aged 65+ by at least 30% between 2007/2008 and 2010/2011, the NHS significantly exceeded the latter (achieving a 71% reduction), but narrowly missed the former, achieving only a 37% reduction (Audit Scotland, 2011c).

Support in achieving these targets has been part of the Scottish Patient Safety Programme initiated in 2008 to improve the safety and reliability of acute hospital care. The overall aims of this Programme – the first countrywide mandatory programme of its kind – are to achieve a reduction by 2012 of mortality in acute hospitals by 15% and adverse events by 30%. By 2011, specific examples of progress included a 73% reduction in central line bacteraemias in ICUs (with none being recorded in the month of March 2011), a 43% reduction in ventilator-associated pneumonias in ICUs, and a 15% increase in on-time antibiotics as a result of increased use of the surgical checklist (Scottish Government, 2011f). In 2012 the programme was extended for a further three years and the hospital-standardized mortality ratio target extended to 20%.

Other specific measures of quality that are commonly utilized include:

- for preventive care, rates of vaccination of children on DTP, polio, Hib, MenC and PCV, on which performance has been stable around 96–98% against a target 95% of children completing courses of vaccination by 24 months, and on MMR for which the target of 95% uptake of one dose

by five years has been exceeded in each year since 2008; and of older people for seasonal influenza, where the WHO target of 75% uptake among people over 65 has been achieved in all but the pandemic flu year of 2009 (ISD, 2011d; Scottish Government, 2011l);

- for long-term conditions, avoidable hospital admission rates for asthma, COPD CHD and diabetes-related complications: on which an 11% reduction in bed days was achieved by 2009/2010 against a target of 8% for 2010/2011 (Scottish Government, 2011f).

7.4.3 Equity of outcomes

HLE has improved over the last decade but a significant gap remains among socioeconomic groups. In 2009/2010 HLE of those living in the most deprived decile was 22.5 years lower for males and 22.1 years lower for females than the HLE of those living in the least deprived decile (Scottish Government, 2011c).

Other indicators of inequality recommended by the Ministerial Task Force (Scottish Government, 2008e) were premature mortality from all causes aged under 75 years, mental well-being of adults, and low birthweight. Recent figures demonstrate the continuing impact of deprivation:

- deaths among those aged 15–44 are six times more common in deprived areas than in affluent areas and, while inequalities have remained fairly stable in absolute terms between 1997 and 2009, they seem to be increasing in relative terms;
- those in the most deprived decile reported a lower mean score of mental well-being than those in the highest decile;
- low birthweight babies are twice as common in deprived areas than in areas of affluence (6.9% compared with 3.3%) (Scottish Government, 2011c).

Concerted action is being taken across all sectors to address these problems. A particular focus for the NHS has been premature mortality from CHD, through the Keep Well programme, which provides health checks in certain areas of high deprivation with positive results. For example, in the 15% most deprived areas, the mortality rate from CHD fell from around 110 per 100 000 population in 2006 to 97 in 2009. The equivalent figures for Scotland as a whole were 62 and 50, indicating that the gap between the national average and the most deprived areas is narrowing slightly (Audit Scotland, 2011c).

7.5 Health system efficiency

7.5.1 Allocative efficiency

Given the stated objectives of all Scottish governments since 1999, the importance of allocative efficiency should be evident in areas such as:

- a greater emphasis on preventive and anticipatory care, to which the Scottish Government has allocated significant additional resources in 2011/2015 (Scottish Government, 2011k);
- a shift in the balance of care away from acute hospitals to services in the community. Overall, there has been a slight increase in the percentage of total NHS resources being spent in the community between 2004/2005 and 2009/2010 (Audit Scotland, 2011c). But there has been no change in the percentage of NHS resources transferred to councils for social care services during this same period. Moreover, almost 60% of the NHS budget is still spent on hospital services;
- equalization of resources across the country in terms of health needs. Chapter 3 outlined the increasingly sophisticated mechanisms for allocation funding to the territorial NHS boards based on needs. Progress is being made towards equalization or "parity", but it has been slow because successive governments have guaranteed that no board should receive an actual reduction in its funding but only differential shares of additional funding. Assessment of progress – and predictions – of convergence toward parity over time are complicated by changes in board populations, but the evidence shows that most boards have moved closer to parity since 2008/2009, although there are notable exceptions (ISD, 2012c).

7.5.2 Technical efficiency

Technical efficiency relates to the ratio between inputs and outputs. There is no single measure but widely used indicators include:

Hospital care

- *average length of stay in the acute sector,* which fell over the last decade from 6.5 to 5.3 days, linked to an increase of 23% in throughput (measured by average number of inpatient discharges treated per bed) (ISD, 2012a);

- *day-case surgery rates,* on which steady progress has been made in increasing the rate of procedures carried out on a day-case basis, with the HEAT target of 80% of British Association of Day Surgery surgical procedures performed in a day-case or outpatient setting delivered for the first time in 2010/2011 (Scottish Government, 2011f).

Pharmaceutical care

- *levels of generic prescribing,* which have increased (measured by proportion of prescription items written using generic drug names) from 73.8% in 2000/2001 to 82.2% in 2009/2010 (ISD, 2011n).

Human resources

- *staff turnover,* which at 7.8 in 2010/2011 was at its lowest rate for five years (ISD, 2011k);
- *sickness absence rates,* which fell in 2010/2011 to 4.74% from a high of 5.55% in 2006/2007, the fourth consecutive year in which the rate has fallen (Scottish Government, 2011f);
- *use of agency staff for nurses* (spending reduced by 84% between 2005/2006 and 2010/2011) (Scottish Government, 2011k) *and of locum doctors* (on which ISD is starting to collect data).

In virtually all these areas, the NHS is moving in the right direction. The challenge, however, is to assess whether progress is as fast as it could have been and, in this respect, how performance compares with that of the rest of the United Kingdom and further afield. Such comparisons, however, are fraught with difficulty as a result of differences in the way in which data are collected.

A Nuffield Trust study of the funding and performance of health systems in the four countries of the United Kingdom published in 2010 concluded that, in 2006/2007, Scotland had the highest levels of poor health, the highest rates of expenditure, and the highest rates of GPs and nursing, midwifery and health visiting staff per capita, but the lowest rates of crude productivity of hospital clinical staff (Nuffield Trust, 2010).

A subsequent study by the Centre for Public Policy for Regions sought to reach a greater understanding of the position in Scotland, particularly in relation to its health needs, and the efficiency and productivity of the NHS in relation to the other parts of the United Kingdom. It concluded that the problems in identifying Scotland's appropriate level of health needs and the relative productivity of the NHS made it difficult to assess how efficient health

services in Scotland are, and that the low degree of comparability of data across the United Kingdom (the Nuffield team themselves acknowledged some data errors, although these did not alter its conclusions) makes it difficult to gauge the relative efficiency of individual systems (CPPR, 2010; see also Donnelly, 2010).

7.6 Transparency and accountability

The transparency and accountability of the NHS have increased exponentially since devolution in 1999. Before 1999 the NHS formed part of the portfolio of one of the junior ministers in the Scottish Office and only rarely did it feature on the agenda of the Westminster Parliament, even among its committees.

In contrast, since 1999 there have always been two ministers with responsibilities for health and, reflecting the fact that health spending accounts for over 30% of the Scottish budget, there are frequent debates on health and community care matters and ministers answer a large number of parliamentary questions from MSPs. In addition, there is a standing Health Committee, which has a role in pre-legislative scrutiny and conducts regular reviews; the Audit Committee, which takes a close interest in the health budget and the financial stewardship of NHS boards; and the Petitions Committee, which gives people the opportunity to bring their concerns to national attention, frequently deals with health matters.

NHS boards predominantly remain bodies whose members are appointed by ministers, but through a public appointments process that is increasingly open and transparent. To extend democratic accountability, a pilot has been undertaken in two areas to introduce a directly elected element, and in two further areas to widen the range of applicants coming forward through the public appointments system, and an independent evaluation has been commissioned that has already produced an interim report (Greer et al., 2011).

A key element of the new performance management system for the NHS has been greater transparency. Boards' annual (now biennial) performance reviews are now conducted by ministers in public and there are opportunities for members of the public to ask questions. Performance, nationally and locally, against the HEAT targets is reported publicly, now as part of the Scotland Performs process. The NHS is also subject to freedom of information legislation.

In tandem with these developments, steps have been taken progressively to extend public involvement in decision-making about the NHS and patient involvement in their care and treatment; and to strengthen partnership working both with NHS staff and with local authorities and the voluntary sector. Landmarks in recent years include:

- the Participation Standard, issued in 2010, which all boards are expected to meet and against which their performance is assessed;
- the Patient Rights (Scotland) Act 2011, which places on ministers the duty of publishing a Charter of Patient Rights and Responsibilities;
- the NHS Reform (Scotland) Act 2004, which imposed on boards statutory duties to promote public involvement and equal opportunities, and in relation to the governance of staff (which underpins the development of partnership working nationally and at local level);
- the Health and Social Care Change Fund to support local health, housing and social care partnerships to improve services for older people;
- new proposals issued for consultation in 2012 to strengthen the way the NHS and local authorities work together and in partnership with the third and independent sectors.

8. Conclusions

This overview of the health system in Scotland has identified a number of key developments in the last decade:

- a substantial increase in funding, which has resulted in significant growth in the clinical workforce;
- marked improvements in population health and in the quality and effectiveness of NHS care and treatment;
- increasing divergence from England, both in health policy and in health systems.

However the future presents daunting challenges:

- closing the persistent gap between Scotland's health status and that of other developed countries;
- reducing health inequalities particularly for those living in the most deprived areas;
- sustaining the range and quality of services in a much less favourable fiscal environment and in the face of demographic and clinical pressures.

The relative stability organizationally of the health system in Scotland provides a supportive environment in which to make continuing progress. The challenge for those involved in government and the NHS is to demonstrate that the distinctive Scottish approach is delivering results at least on a par with those in other systems, and to articulate it convincingly as an alternative to market-driven approaches.

From a research perspective, the growing divergence in approaches presents considerable scope for learning across borders, not just with England but also with Wales and Northern Ireland, which in many respects are more

appropriate comparators, despite the methodological and data difficulties that have hampered comparative analysis in the past but which can be overcome (see for example work on health inequalities by Blackman et al., 2009 and Smith et al., 2009).

Overarching all the health challenges facing Scotland is uncertainty about its future constitutional status, on which a referendum is due to be held in 2014. If Scotland becomes independent, the impact on the NHS will depend critically on the terms that are negotiated, for example in relation to the division of revenues from North Sea oil and gas, on the currency and on monetary policy, and on membership of the EU. If Scotland votes to remain within the United Kingdom, there are likely to be political challenges due to the relatively higher level of spending on health north of the border and to differential access to services as a result of divergence in policy and priorities.

9. Appendices

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9.2 List of principal legislation

UK Parliament

Medicines Act 1968

NHS (Scotland) Act 1978

Scotland Act 1998

Health Act 1999

Scotland Act 2012

Scottish Parliament

Adults with Incapacity (Scotland) Act 2000

Public Finance and Accountability (Scotland) Act 2000

Regulation of Care (Scotland) Act 2000

Community Care and Health (Scotland) Act 2002

Freedom of Information (Scotland) Act 2002

Mental Health (Care and Treatment) (Scotland) Act 2003

NHS Reform (Scotland) Act 2004

Disability Discrimination (Scotland) Act 2005

Adult Support and Protection (Scotland) Act 2007

Public Health (Scotland) Act 2008

Health Boards (Membership and Elections) Act 2009

Patient Rights (Scotland) Act 2011

9.3 Useful web sites

Audit Scotland
www.audit-scotland.gov.uk

Better Together – Scotland's Patient Experience Programme
www.bettertogetherscotland.com

Community Pharmacy Scotland
www.communitypharmacacyscotland.org.uk

General Register Office for Scotland (now part of National Records of Scotland)
www.gro-scotland.gov.uk

Healthcare Improvement Scotland
www.healthcareimprovementscotland.org

Health Protection Scotland
www.hps.scot.nhs.uk

Health Rights Information Scotland
www.hris.org.uk

Information Services Division
www.isdscotland.org

NHS Education for Scotland
www.nes.scot.nhs.uk

NHS24
www.nhs24.com

National Services Division
www.nsd.scot.nhs.uk

NHS National Services Scotland
www.nhsnss.org

Scottish Executive
Documents can be accessed via Scottish Government web site

Scottish Government
www.scotland.gov.uk

Scottish Health Council
www.scottishhealthcouncil.org

Scottish Health on the Web
www.show.scot.nhs.uk

Scottish Office
Documents can be accessed via Scottish Government web site

Scottish Parliament Information Centre
www.scottish.parliament.uk

Scottish Public Health Observatory
www.scotpho.org.uk

Scottish Public Services Ombudsman
www.spso.org.uk

Scottish Patient Safety Programme
www.scottishpatientsafetyprogramme.scot.nhs.uk

9.4 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined

by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.

6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.5 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

9.6 About the authors

David Steel was Chief Executive of NHS Quality Improvement Scotland from its creation in 2003 until March 2009. After 12 years as a Lecturer in Public Administration at the University of Exeter, he moved into NHS management in 1984 as Assistant Director of the National Association of Health Authorities. From 1986 until 2009 he held various senior posts in the Scottish Office Health Department and in NHSScotland. In retirement he is Senior Research Fellow at the University of Aberdeen and chairs the Prioritisation Panel of the National Institute for Health Research, Health Services and Delivery Research Programme. He was awarded an OBE for services to health care in 2008.

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The Health Systems in Transition profiles

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- to learn in detail about different approaches to the financing, organization and delivery of health services;
- to describe accurately the process, content and implementation of health reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

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Belarus (2008[g])
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Georgia (2002[dg], 2009)
Germany (2000[e], 2004[eg])
Greece (2010)
Hungary (1999, 2004, 2011)
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Ireland (2009)
Israel (2003, 2009)
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Kyrgyzstan (2000[g], 2005[g], 2011)
Latvia (2001, 2008)
Lithuania (2000)
Luxembourg (1999)
Malta (1999)
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Mongolia (2007)
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New Zealand (2001)
Norway (2000, 2006)
Poland (1999, 2005[k], 2012)
Portugal (1999, 2004, 2007, 2011)
Republic of Korea (2009)
Republic of Moldova (2002[g], 2008[g])
Romania (2000[f], 2008)
Russian Federation (2003[g], 2011)
Scotland (2012)
Slovakia (2000, 2004, 2011)
Slovenia (2002, 2009)
Spain (2000[h], 2006, 2010)
Sweden (2001, 2005, 2012)
Switzerland (2000)
Tajikistan (2000, 2010[gl])
The former Yugoslav Republic of Macedonia (2000, 2006)
Turkey (2002[gi], 2011)
Turkmenistan (2000)
Ukraine (2004[g], 2010)
United Kingdom of Great Britain and Northern Ireland (1999[g])
United Kingdom (England) (2011)
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Key

All HiTs are available in English.
When noted, they are also available in other languages:

a	Albanian
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l	Tajik

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HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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