Health inequality and governance in Scotland since 2007

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Keywords:
Health policy
Health inequality
Determinants of health
Scotland

Abstract

Background: Since Scottish devolution in 1999, successive governments have accorded priority to reducing health inequality and increasing economic growth. The Scottish Nationalist Party Government elected in 2007 and re-elected in 2011 has accorded considerable attention and allocated substantial resources to addressing these priorities. This article describes why, how and with what results to date the participants in the governance of Scotland, broadly defined to include persons outside as well as within central government, have addressed the determinants of health in order to reduce inequality and, as a result, improve the health status of the population.

Study design: Interpretive analysis.

Methods: Research for this article applied the methods of interpretive social science to obtain and analyse published and unpublished public documents; secondary sources in relevant disciplines; and interviews with ministers, officials, staff of National Health Service Scotland and its regions, and other persons active in health governance in Scotland.

Results: Participants in the governance of health affairs in Scotland are making important contributions to the reduction of health inequality and the improvement of population health by: (1) linking policy to address health inequality with policy to make health care, public health, social and housing services, and education more effective and efficient; (2) linking policy to address the determinants of health with policy to stimulate economic growth and, as a result, increase employment and income; and (3) embracing and applying a unique synthesis of research findings about the causes of deficiencies in population health status that contribute to health inequality.

Conclusions: These findings could contribute to revising the assumptions and recommendations of some of the researchers and policy advisers who study the determinants of population health, and thus of health inequality, in order to recommend policy. Many contributors to the literature on population health argue that the determinants of health are universal, and that effective interventions to address them are likely to be universal. Research for this article suggests, however, that participants in the governance of one country, and perhaps of each country, take account of its culture, history and current politics when they describe the determinants of health in order to propose policy to reduce health inequality. The Scottish experience described in this article could, therefore, contribute to conversations about health policy that involve leaders in governance from numerous jurisdictions; conversations that have been occurring regularly for two decades.
Introduction

Since Scottish devolution in 1999, successive governments have accorded high priority and increased resources to improving health, in order to increase the rate of economic growth and address the socio-economic causes of inequality in health status in a population for which there are no barriers to accessing health services. This article addresses how Scottish governance has addressed health inequality since devolution, with particular emphasis on events since 2007 under governments led by the Scottish National Party (SNP).4

The high priority accorded to reducing inequality in health status has had measurable effects. The budget for the ‘community sector’ of the devolved National Health Service (NHS) increased gradually between 1999 and 2010. The minority government of the SNP elected in 2007 and re-elected with a majority in 2011 increased spending to reduce health inequality by both the NHS and local authorities. Evidence is accumulating that several recent initiatives are having a positive effect. However, public spending in Britain has been reduced since 2010 as a result of budget ‘austerity’ under the current coalition government of the UK.

Governance is a broader concept than government. The definition used in this paper is: in a particular jurisdiction, who does what to, for and with whom to achieve what goals. Like other contributors to the literature of history, law and political science, I use ‘governance’ as a broad, analytical concept. This definition emphasizes the influence of history on the multisectoral politics of making, implementing and evaluating policy. The study of governance also includes examining the reliability, validity and political salience of the evidence used to justify, defend and modify policy.

The definition accords with recent scholarship explaining why the study of governance, rather than of government alone, is necessary.1,2 As a political scientist wrote, summarizing the views of other scholars, states are ‘fragmented, consisting of complex networks of actors inspired by different beliefs, formed against the background of competing traditions’.3,4 In contrast, the most frequently used definition of governance in the literature on public health is limited to formal relationships within and among organizations.5

This conceptualization of governance stimulated my curiosity about how key participants in making decisions about health affairs in Scotland addressed three questions that are frequently asked in other countries. How do influential persons in governance balance the competing claims on resources of policy to reduce health inequality and policy for health care? How do these participants in governance address the relationship between policy for economic growth and policy that seeks to reduce health inequality? How do policy makers and other participants in governance take account of international research on the socio-economic and biological determinants of health in addressing health inequality?

The analytical and historical approach to studying governance that led me to ask these questions differs from the normative approach to studying governance preferred by many contributors to the literatures of political science, public management and public/population health.6 There are, for instance, many articles and reports that address what their authors consider to be attributes of ‘good governance’ and their relevance to improving the health of populations globally.7 Thus, the organizers of the World Conference on Social Determinants of Health in October 2011 made improving governance the first of five leading themes of their technical paper but did not acknowledge the relevance to improving health of the history, culture and current politics of each jurisdiction.8

Much of the international literature on improving population health defines governance as what ought to be done. As a result, its authors accord more importance to interventions that, they assume, could be effective anywhere than to how governance in each jurisdiction affects policy and its implementation. Some contributors to this literature, for example, emphasize evidence about the benefits of policies that they consider to be universally effective, particularly policies that reduce inequality.9,10 Others compare efforts to apply universal policy templates among jurisdictions in order to derive lessons that can be generalized.11–14 Still others conduct cross-national comparisons of priority-setting processes or of spending to address various determinants of health, again without explicit attention to the effects of governance on policy.15

This article, in contrast, seeks to answer questions about the governance of recent health policy in Scotland, and then to generalize, cautiously, about the potential relevance of these answers for leaders of governance in other countries. Although I foreground the governance of health affairs in Scotland, I know that policy makers and their advisors in Scotland are aware of international research on the determinants of health and policy to improve population health in other jurisdictions. They adapt findings from this research to the social, economic and political environment and the history of Scotland, as do their peers in other jurisdictions. (I allude to the adaptation of international literature in Scotland in order to clarify how normative research on governance differs from a policy-neutral approach to research and analysis.)

Methods

Research for this article applied methods that Bevir and others call interpretive social science.3 This methodology prioritizes history and contingency over formal theory and models. The goal of interpretive social science is to offer coherent and plausible narratives of events and explanations for them that are grounded in documents generated by participants in particular events, as well as conversations, and observing them in action. Validity and reliability in interpretive social science is achieved by gathering and making judgements about information from multiple sources, rather than, as in other methods of social science, testing hypotheses and seeking congruity between theory and models.
Practitioners of interpretive social science have usually been trained in one or more of the disciplines that are often described as the ‘policy sciences’: history, political science; political economy; political sociology; and public administration or management. In addition, some of the most influential practitioners are journalists, many of whom are familiar with the methodology of one or more of these disciplines.

Practitioners of the policy sciences and of investigative and interpretive journalism are opportunistic in acquiring human and documentary primary sources. That is, they begin their research with one or more questions in mind and then identify and, if possible, interview people who have first-hand knowledge that could help them answer these questions. They invite these informants to refer them to other knowledgeable people and to relevant published and unpublished written sources.

Opportunistic sourcing with persons who make and implement policy requires a trade-off between access and confidentiality. A researcher conducting interpretive social science or an investigative journalist will only acquire useful evidence when their informants control whether and how they are identified. In this article, for example, I name some informants and give their titles, describe others by profession or as ‘officials’, and accord anonymity to several others.

Moreover, opportunistic sourcing in a limited period of time necessarily limits the breadth of research. Without time constraints, I could have spent several (enjoyable) years applying the methodology of opportunistic sourcing to gathering evidence about how governance addresses health inequality across Scotland. Although senior officials in the Scottish Executive talked with me about the entire country, I only interviewed managers and front-line staff of health regions and local authorities in two regions. I remedied, but only partially, this limitation of my research by asking experts with regions and local authorities in two regions. I remedied, but only partially, this limitation of my research by asking experts with first-hand experience in most of the health regions to review parts of the UK. Moreover, the comparatively small size of the country to ‘a movement [across Europe]…that is transforming the geography of power and changing the scale of government, below the state, above it and across it’.22

Paul Addison recently summarized an ironic contribution of British policy to the governance of the health sector in Scotland. British governments since the 1950s, he wrote, ‘under the impression that they were outmanoeuvering nationalists’, created ‘devolutionary platforms on which nationalists could stand’.23

Like these academics, many of the officials and other participants in Scottish governance whom I interviewed described differences between governance in Scotland and the other countries of the UK, especially England. Scottish governance, they agreed, is more consensual and consultative than elsewhere in the UK. A senior official described a ‘widely held belief amongst [my colleagues] that we are better connected to other influential figures than is the case in other parts of the UK’. Moreover, the comparatively small size of the senior civil service (about 250 people) contributes to collegiality among officials and between them and other influential Scots. Several persons described Scotland’s ban on smoking in public places, the first in the UK, as a result of Scotland’s unique governance. Everyone I interviewed emphasized that, despite intensely competitive politics, there is consensus about the principles of social democracy and their centrality in governance among adherents of the Labour, Liberal-Democratic and Scottish Nationalist Parties.

There was also agreement that reducing socio-economic inequality and its effects on health status has been important to leading participants in Scottish governance for many years. Harry Burns, the Chief Medical Officer of NHS Scotland, for example, described a ‘relentless’ commitment to reducing health inequality within and outside government during the past quarter century. He added that his predecessors had shared this commitment since the 1970s.24

The use of policy to reduce health inequality has increased since devolution. In 2000, a year after devolution, a Labour—Liberal Democratic coalition government, announced ‘a clear commitment to improve the health of the people of Scotland and to tackle inequalities in health between the rich

The context of health policy in Scotland

Health care in Scotland has, since 1948, been administered by and financed through the NHS. As occurs everywhere in the UK, care is universal and free of charge at the point of service. Unlike in many other countries, moreover, general practitioners (GPs) have a monopoly on primary care, and specialists (‘consultants’) have a monopoly on secondary and tertiary care.

Nevertheless, significant aspects of health policy in Scotland have been unique since before devolution in 1999, and even before the establishment of the NHS. The ‘UK welfare state took a distinctive form in Scotland’ because the country ‘had its own welfare state bureaucracy’.27 ‘Scottish health [policy] had never been anything but devolved’, the author of a recent comparative study concluded. The Scots, he added, have become ‘accustomed to being left alone by any [UK] government in many fields of health policy’.18 In a subsequent study, he argued that health policy is more important in Scottish than in English governance because the Scots have ‘no taxation, war…and not much economic management to compete with it’.19 Moreover, because ‘Scotland has long had high status medical leaders who are closely connected with policy [the country has experienced] politics that values professionalism as well as professionals’.20

Another expert on devolved government, and on governance more broadly, in Scotland and Europe described a ‘distinct conception of the welfare state at the elite level in Scotland’. He observed that leaders of the public and private sectors and the professions have been ‘more favourable to universalism’ than their counterparts elsewhere in the UK.21 In recent decades, moreover, the divergence of governance in Scotland from that of other UK jurisdictions has linked the country to ‘a movement [across Europe]…that is transforming the geography of power and changing the scale of government, below the state, above it and across it’.22

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and the poor.\textsuperscript{25,26} In 2005, the Strathclyde (Glasgow) police created a Violence Reduction Unit in order to apply ‘a public health approach to tackling violence’. The Unit, which became a national service in 2006, described Scotland as ‘the only country in the world to do so’.\textsuperscript{27} In June, 2008, a ministerial task force appointed by the SNP Government elected a year earlier reported, after considerable external consultation, that ‘health inequalities remain the major challenge’. Introducing the report, Equally Well, First Minister Alex Salmond said that ‘reducing health inequalities is vital to achieving the Scottish Government’s overall purpose: sustainable economic growth’.\textsuperscript{28}

### Evidence of health inequality

Scotland lags behind other European countries in mortality and in the prevalence of major chronic diseases and associated risk factors. A substantial literature documents this lag and explores its relationship with socio-economic disadvantage and poverty as well as its broader cultural context. Mortality among persons of working age has been the highest among the countries of Western Europe since the 1970s.\textsuperscript{29} Research published in 2008 found that mortality trends in West Central Scotland (the Glasgow region) ‘compare badly with other, similar postindustrial regions of Europe, including regions of Eastern Europe [with] higher levels of poverty’.\textsuperscript{30} In 2010, Scottish men were the eighth and women the 13th most obese in the world.\textsuperscript{31} Moreover, residents of Liverpool and Manchester, where industrial economies also declined and levels of deprivation are similar to Glasgow’s, experience better health outcomes than those of the Glasgow region.\textsuperscript{32}

Scottish officials and journalists frequently cite these comparisons. Burns, for example, began his report for 2009 by warning that, ‘although life expectancy has continued to improve in Scotland, other western European countries have experienced faster increases’.\textsuperscript{33} A newspaper headlined its story on Burns’ report, ‘Health of Scots falling behind Eastern Europe’.\textsuperscript{34}

### Addressing health inequality under the SNP Government

The SNP has invested considerable political capital to link economic development through a free market with reducing differences in health status between Scotland and other regions and countries. Adam Ingram, Minister for Children and Early Years, traced the history of the linkage to the Scottish Enlightenment of the 18th Century. Then he quoted Hugh MacDiarmid, a significant 20th Century poet who was a nationalist as well as a Marxist. To him, the linkage of individualism and collectivism was one of the ‘contradictions of the Scottish nature’. A senior civil servant who works closely with ministers said that the SNP seeks to strengthen national identity and support independence by linking health and the economy. A long-time SNP activist wrote that the SNP has an ‘economic head and [a] social heart’.\textsuperscript{35}

Several people I spoke with said that devolution, in its current form, constrains policy to address health inequality. For example, Ron Culley of the Convention of Scottish Local Authorities criticized SNP activists who point to the Nordic countries as models for linking market economies and welfare states. According to Culley, ‘Scots aspire to the mortality of a Scandinavian country but lack the means to support that aspiration’, mainly because the UK Government retains nearly all authority over taxes. Others noted, however, that despite needing more money to achieve its goals, the SNP is also committed to keeping taxes low. One informant described SNP tax policy as ‘more like Ireland’s before the Great Recession than Scandinavia’s’.\textsuperscript{36}

Many leaders of the SNP, I was told, regard the Nordic countries as models of managerial competence. According to these informants, the SNP has been eager to demonstrate similar managerial competence in order to justify independence and muster votes for the referendum on it in 2014. Similarly, SNP leaders seize opportunities to host and participate in international meetings (of World Health Organization projects, for instance) in order to demonstrate, an informant said, Scotland’s ‘ability to play on a world stage’.

The minority status of the SNP Government between May 2007 and May 2011 both stimulated and constrained policy to address health inequalities. According to Shona Robison, Minister for Health and Sport, the ‘nature of minority status’ required the SNP to have ‘unity of purpose’ and to be ‘disciplined’. She cited as an example the development of Equally Well, the major statement of government policy on health inequality, issued in June 2008. ‘We all saw the big picture’ as a result of writing this report, she said.

Minority government had limits, however, despite the SNP’s unity and discipline. Robison described, for instance, how the Government increased awareness of alcohol abuse as a particularly large problem in Scotland. However, it failed to persuade a majority in Parliament to support legislation setting minimum prices for alcoholic beverages mainly because of uncertainty about whether such a policy would reduce consumption.\textsuperscript{36}

Unity had emboldened the SNP to accept the political risk of supporting this controversial policy. As an example of risk taking, Peter Donnelly, Professor of Public Health Medicine at The University of St. Andrews, noted that the SNP had endorsed minimum alcohol pricing throughout its 5 years of minority government as well as in the election manifesto that preceded its victory in 2011.

Similarly, Adam Ingram described how the unity of a minority government created incentives for innovation in other areas of policy. For example, the SNP found leverage, even without a majority, to mandate that local government finance newly integrated services for children and families. Local authorities, most of which have Labour Party majorities, had wanted more discretion in spending. The SNP offered them more discretion accompanied by a 2-year freeze on local taxes. The 32 local councils could express their preferences when they negotiated contracts with the Government that stipulated what services each of them would provide (these contracts are called ‘Single Outcome Agreements’). Ingram called this voluntary collaboration to increase service integration ‘a culture change’.

According to Ingram, the Government also exerted authority by funding new or expanded programmes and through
its responsibility for inspecting and reporting on services. Inspection is often effective, he said, because ‘nobody likes to be identified as a poor performer’. Ingram as well as staff members of NHS regional boards said, however, that, in the absence of statutory authority, some innovations to reduce health inequality would probably be unsustainable as a result of reductions in Scotland’s share of UK tax revenues during austerity or following independence.

Nevertheless, the political effectiveness of SNP leaders may also be, in part, a result of the effects on their careers of their commitment to independence. For generations, Donnelly recalled, ‘bright Labour politicians went to Westminster’ while most ‘bright SNP politicians had no place to go but home’.

Continuity or discontinuity in health policy?

Officials of the Scottish Executive disagree about the extent to which the health policy of the SNP Government differs from the preceding coalition of Labour and Liberal Democrats. Reflecting on his experience as an official under both governments, Donnelly recalled that the SNP Government ‘systematized the equality agenda’ into a ‘comprehensive approach’, unlike its predecessor which had ‘personalized’ it. He described a Labour minister who had decided to support restrictions on smoking in public places after a visit to Dublin during which he observed that it was ‘good politics’. Another minister who had three daughters took a prominent role in policy to improve sexual health.

An official who also emphasized discontinuity between the SNP Government and its predecessors since devolution said that it was ‘quite courageous’ in advocating reduction in health inequalities ‘as part of national identity’. The Government was, moreover, ‘focused and strategic’; for example, in setting fewer priorities than its predecessor and reducing compartmentalization of authority within the Scottish Executive. Another official called this change within the Scottish Executive ‘focusing’, and ascribed it to the SNP Government making sustainable economic growth its top priority. Prioritizing growth required initiatives to address ‘[distressed] areas, workforce [and on] deprivation and multiple health issues’. The cabinet members, she continued, are the ‘best politicians I’ve worked with at seeing the inter-relationship of issues’.

Several informants attached particular importance to Nicola Sturgeon, who was both the Secretary for Health and Well Being and Deputy First Minister between 2007 and September 2012. Holding both portfolios, they said, gave her sufficient authority to prevent or defuse internal conflict about allocating resources to health. One of them added that Salmond deferred to Sturgeon because her support had been critical to his election as First Minister.

Several officials, however, minimized the difference between the SNP Government and its predecessors on policy to improve health. They described a history of cross-party support for reducing health inequalities, and emphasized continuity in the influence of senior civil servants on policy. One of them recalled, for example, that several years before the election of 2007, she and her colleagues had started to address compartmentalization within the Scottish Executive, and thus created the administrative basis for the SNP Government’s prioritization of service integration to reduce health inequality. Moreover, the preceding Labour–Liberal Democratic coalition had conducted reviews of health inequality, of the outcomes of intervention in the early years of life and of anti-poverty strategies. ‘During the run-up to the election of 2007’, another official said, ‘the great and the good in the civil service began to identify cross-cutting themes’ pertinent to these reviews that ‘went wider than the department’. The discussion about these themes — ‘wealthier, healthier, safer, smarter etc...’ — hinted at connections between what had been seen as distinct policy areas’.

Under the previous government, this official recalled, senior civil servants devised a plan to re-organize the Scottish Executive by ‘getting rid of departments’. They proposed that the Permanent Secretary would make each Director General of a policy area within the Scottish Executive responsible for coordinating work on a particular ‘theme’. As a result of discussing re-organization ‘across the senior parts of the organization, [we] began to think seriously about connections between what had been previously regarded as separate’. In 2007, the new SNP Government ‘grasped [these connections] with open arms because its nationalist ideology was conducive to policy integration’. Ministers told the civil service, ‘We’re seriously joined up and we expect you to be joined up too’.

Another senior official augmented this interpretation of events. He recalled that several years before the election of 2007, he and colleagues in the Scottish Executive had devised an ‘outcomes approach’ that would be implemented through increased service integration. Their proposal to prioritize measuring outcomes ‘reflect[ed] public perspectives’ about the quality and effectiveness of services, he said. After the election, ‘thinking that had gone on among officials suddenly found an outlet in the incoming Administration’. Non-political officials subsequently had a significant role in ‘maintaining the public conscience on outcomes policy’, he observed.

How research informs policy to address health inequality

Although the precise influence of any research on policy is notoriously difficult to document, there are recent examples from several countries of senior elected and appointed officials as well as civil servants using research results to inform policy for allocating resources, and for organizing, paying for and delivering health services. Moreover, there is growing documentation of these examples, including how policy makers are defending evidence-based policy against attacks from within and outside government. In most of these countries, policy makers rely on trusted researchers, mainly but not exclusively academics, for the findings they translate into policy.

Scotland may, however, be the only country where policy to reduce health inequality (often called ‘improving population health’) has been informed by a unique synthesis of research; a synthesis, moreover, that a senior official devised and disseminates. Evidence is accumulating that this
synthesis is respected by a growing number of health professionals and other workers as well as by other participants in governance. I describe the Scottish synthesis in some detail because of its potential interest to policy makers – as well as to researchers who hope to influence them – in other countries.

Harry Burns, the principal author and communicator of this synthesis, began to develop it before he became Chief Medical Officer in 2005. Burns draws the elements of the synthesis from extensive cross-disciplinary reading and his previous work as a clinician, researcher and public health executive. He said that he is hoping to organize a ‘movement’ to promote use of the synthesis in policy and practice.

In Burns’ synthesis, health inequality is a result of the ‘biological consequences of social phenomenon’. He describes inequality as primarily a consequence of adverse events in economies, communities and families; not, as some epidemiologists assert, the cause of such effects.10

Burns begins his explanation of health inequality with findings from neuroscience. He emphasizes findings about the effects of deprivation on the central nervous systems of experimental animals and similar results from studies of children. Most of this research found that the effects of deprivation often persist in adult life.10

The interventions that Burns proposes in order to remedy the effects of deprivation are informed by the findings of studies of differences in individuals’ capacity ‘to make sense of the stresses they encounter’. These studies found that persons who do not develop a ‘sense of coherence’ become ‘chronically stressed’, and that such stress, in combination with the stresses of socio-economic inequality, contributes to the development of chronic disease, both physical and mental.39–44

The priority of policy to improve population health, Burns reasons, should be to ‘increase resilience in the young people’ and ‘support adults who lack the incentives to engage with their social environment to do so’. He rejects interventions to improve health that address the ‘deficits’ of individuals in favour of programmes that help them develop a ‘sense of control over their lives’.

Burns advocates the implications of this synthesis for policy and practice within and outside government. He estimates, for instance, that in 2010, he spoke to 10% of the teachers in Scotland. News media frequently report on the synthesis and the recommendations based on it. A newspaper headline quoted him in December 2009, for instance: ‘Harry Burns: “properly functioning families are the key to making Scotland healthier”’.45 Similarly, he told a reporter for the BMJ that the goal of policy should be to ‘shift from health improvement to broader life improvement’.46

Many people testify to Burns’ persuasiveness. Minister Adam Ingram described his ‘tower of work in presenting the agenda [for reducing health inequalities] to many audiences’ and ‘establishing a consensus’. Drew Walker, Director of Public Health for the Tayside NHS region (based in Dundee), said that Burns’ ‘vision, intellect and passion’ had a profound influence on the development of that region’s ‘healthcare strategy’. According to another public health doctor in Tayside, Karen Adam, ‘You hear colleagues in local government and social work say, ’I heard Harry Burns talk’’. She added that the influence of his talks is enhanced because ‘he never tells us what to do’.

The goal of the Glasgow Centre for Population Health (GCPH) is to conduct research that could inform policy. GCPH, which has counterparts in several other countries, is a partnership of the Scottish Government, the NHS Health Board for Greater Glasgow and Clyde, Glasgow City Council and the University of Glasgow. The Scottish Government provides all of its direct funding (£1 million pounds/year in 2010).47

Carol Tannahill, Director of the GCPH since its inception, believes that the relatively small size of Scotland contributes to its influence on policy. ‘There is something about knowing the people who do and use the research’, she said.

According to Tannahill, studies by GCPH staff and associates have had national as well as local influence. The GCPH contributed analysis to the ministerial task force that produced Equally Well. Its research in metropolitan Glasgow has influenced the Health Commission, school food policy, the East End Development Plan as well as the NHS.48

Other organizations apply research results in order to inform the implementation of NHS policy to improve the quality, safety and efficiency of health care while addressing the persistence of inequality. A senior official who described ‘health care and population health as a continuum’ said that ‘the big issues in health care for us are quality and patient safety’. NHS Quality Improvement Scotland (NHS QIS)5 dissemminates advice to clinicians that is grounded in international research on effectiveness and quality improvement. The Scottish Intercollegiate Guidelines Network, an international leader in developing practice guidelines based on systematic reviews since 1993, became a unit of NHS QIS in 2005. NHS QIS also has programmes for ‘driving and supporting improvement’ and ‘assessing the performance of the NHS and published its findings’.

The official explained that ‘our strategy for at least six years’ has been to link improvement in quality, efficiency and population health. NHS Scotland contracts for technical assistance with the Institute for Healthcare Improvement (IHI) of Cambridge, MA, USA, an organization that promotes this linkage internationally through a programme it calls ‘Triple Aim’. IHI is assisting two NHS regions to apply research and experience from other jurisdictions. However, this official emphasized, ‘Triple Aim was our idea before it was IHI’s’.

The same official said that, even though hospitals ‘are still the dominant domain’, Scotland is making substantial progress in improving quality, efficiency and population health improvement. Progress is possible, he continued, because better health is a ‘genuinely national programme’ that has widespread support among participants in governance. Leaders of governance from the public and private sectors are committed to ‘be in [the effort to improve population health] for the long haul’. However, the long haul includes measurable intermediate points for politicians and officials. ‘My aim’, he emphasized, ‘is that we wouldn’t need [IHI] after three years’.

The NHS in England, unlike NHS Scotland, is ‘fragmented by geography and competition’ and accords more emphasis to improving productivity than to how patients experience care, he noted. Several recent publications comparing the Scottish

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11 Now Healthcare Improvement Scotland.

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NHS unfavourably with its English counterpart, he added, mistakenly defined productivity narrowly.\textsuperscript{49,50} Donnelly told me that these reports used data and assumptions that were at least open to challenge.\textsuperscript{51}

Another Scottish official, however, emphasized contrary findings from a study of health policy in the devolved governments of the UK. The authors of this study concluded that policy ‘discourse’ in Northern Ireland, Scotland and Wales ‘had significant similarities in the interventions [for] targeting health behaviour’, especially in prioritizing quick wins from pharmacological interventions’, and in making ‘limited use of evidence about efficiency’. They did not, however, compare the priority the devolved governments accorded to reducing health inequality. Neither did they address what almost everyone I spoke with described as the unique political culture of Scotland.\textsuperscript{52}

**NHS regions and local government**

Relationships between the geographic regions of NHS Scotland and local authorities influence how national policy is implemented. As the 14 regional health boards, nine ‘special boards’ and 32 local authorities have different but overlapping responsibilities, patterns of joint funding and service integration vary across the country. Health boards, which are funded entirely by the Scottish Executive, manage hospitals and contract with GPs and pharmacies. Local authorities receive 80% of their revenue from the Scottish Executive. Their work includes managing education, housing, social services, environmental health, planning, and licensing pubs and taxis. Until 2008, when the Scottish Parliament mandated a pilot project of direct elections for health boards, the elected councillors of local authorities were more closely involved in partisan politics than members of NHS boards. Since legislation in 2009, moreover, health boards have been required to reserve seats for each local authority in their region.\textsuperscript{53} Variation between local authorities, as a result of their relationships with health boards, is codified in the benchmarks and anticipated outcomes in the Single Outcome Agreements.

These differences in the responsibilities and financing of boards and authorities are exacerbated by cultural differences and interpersonal relationships. As a result, how governance affects the implementation of the goals set forth by the government in Equally Well varies across Scotland. The effects of local and regional variation have, however, been described mainly in anecdotes and in studies measuring processes and outcomes in projects that affect small populations.

As publications about budgets and spending in Scotland usually array data by object of expenditure (e.g. personnel, supplies, equipment, rent and travel) rather than by particular programmes, it is difficult to relate expenditures and outcomes, either centrally or locally.\textsuperscript{54} Local authorities have resisted efforts to institute programme budgeting since the 1970s. The reason for resistance, according to a former official of the Scottish Executive, is that local authorities regard programme budgets as limiting their ability to manage resources in response to voters’ preferences. SNP ministers worry, he said, that publishing more detailed information about expenditures and outcomes might cause them to be regarded as big spenders and hence as ‘high taxers’. They prefer local authorities alone ‘answering for shortfalls’ in spending and outcomes.

Nevertheless, information that is less precise than analysis of spending under programme budgets demonstrates that the priority accorded to reducing inequalities had changed after 3 years of the SNP Government. Between the fiscal years 2006/07 and 2009/10, spending for the broad category of ‘community health services’ increased from 13% to 15.3% of the total NHS budget. In the same years, expenditures for hospital care declined from 60% to 57.3% of the total. However, spending for ‘family health services’ (primary care, dental, ophthalmic services and prescription drugs) had declined from 27% to 24% of NHS expenditures.\textsuperscript{35–57}

Informants in the two NHS regions I visited, Glasgow and Tayside, provided examples of how local governance affects the implementation of national policy. In what follows, I accord more attention to Glasgow because stories about conflict take longer to tell than those about consensus.

The history of the Community Health Care Partnership (CHCP) in Glasgow, especially North Glasgow, exemplifies how differences in statutory duties, functions and finances between a health board and a local authority can impede implementation of national policy to integrate health and social services. The population of North Glasgow has ‘the worst health in Scotland and in Western Europe’, according to a participant in this history. For example, 60% of area residents are among the 15% of Scots with the worst health.

The CHCP began in 2006 as one of five pilot projects across Scotland.\textsuperscript{58} Seventy percent of its annual budget of approximately £100 million has been financed by the NHS, and the other 30% by Glasgow Council through its budget for social care. The directors of the CHCP programmes serving five geographic areas in Glasgow reported to the Health Board and the Council. Since inception, the 1200 employees of the five pilot projects have, I was told, ‘engaged [directly] with 75–80% of the individuals enrolled in primary care practices in North Glasgow and, as a result, ‘increased uptake of [health and social] services’. CHCP staff provided or co-ordinated services of district and school nurses, dentists, pharmacists, public health practitioners and health workers who provide care for persons with mental illness, learning disabilities and addictions.

The CHCP documented its results against a ‘consistent performance framework’. Most GPs and their staffs, one source said, regard CHCP as ‘part of [their practices]’ primary care teams’. The quit rate for smokers in support groups increased from 48% in 2008/9 to 56% in 2009/10. Between 2007 and 2009, the percentage of babies exclusively breast fed at 6 weeks increased from 17.2% to 20.3%. The number of 3–5 year olds registered with dentists increased from 56.6% to 71.5% between 2007 and 2010.\textsuperscript{59}

Glasgow Council and the NHS Board ended the joint-funding arrangement for the CHCP in central Glasgow in 2010.\textsuperscript{60} Jointly-funded CHCP activities continue, however, in other areas of the Glasgow health region. Several sources said that budget constraints caused Glasgow Council to eliminate funding of the CHCP in central Glasgow.

I also heard other explanations. Members of the staff of the North Glasgow CHCP said that the rupture occurred because local authority officials wanted to control their funds and...
employees more tightly. One of them attributed the Council’s decision to ‘cultural differences’ between the NHS and Social Care; another to clashes of personality. An example of cultural differences, I was told, was that the NHS negotiated savings targets and permitted transfers among objects of expenditure while Social Care ‘decided what to cut’ and prohibited re-allocation of funds. Another source attributed the end of joint funding to turmoil about the Council’s leadership and to the ‘culture [of the Glasgow NHS Board] which doesn’t permit its senior officials to talk informally’ with leading councillors.

Linda de Caestecker, Director of Public Health for the NHS Board for Greater Glasgow and Clyde, told me that the controversy about the CHCP was connected to the harsh fact that ‘we are not narrowing the gap between rich and poor’. The cause of failure, she continued, is that ‘we are not following through on policy by the way we allocate our budget’. For example, there had not been ‘any shift [of funds] from health care to population health’. Healthcare savings from interventions to prevent illness had, for instance, not been re-allocated to reduce inequalities. Only the central government could achieve ‘genuine re-allocation’ of resources.

De Caestecker also offered evidence of success in her region. Glasgow Council and the Chief Constable, she said, proposed to re-allocate funds to the Early Years programme because the murder rate had declined. This transfer did not occur ‘partly as the Scottish Government found other sources of funds to allocate’ for the programme but also, several sources said, because of tensions among participants in negotiations about re-allocation. In contrast, the Education Authority had established new programmes for children with behavioural problems. Moreover, as a result of decentralization of resources from the Scottish Executive to NHS regional boards, ‘locality managers’ can ‘target’ programmes more effectively. As examples, she described reduced prescribing of prescription drugs and increased access to psychological therapy for persons with clinical depression.

In contrast to the conflict in Glasgow between the Health Board and the Council, NHS staff in Tayside (Dundee) reported that collaboration with the local authority to integrate health and related services had usually been effective. Examples included working with members of the local council and participants in civic forums to implement new national licensing standards for vendors of alcoholic beverages, joint funding with the local authority for integrating health and mental health services with social care, and collaborating with the local education authority to design a new health curriculum. NHS staff in Tayside said that their most important success to date had been persuading the regional health board to adopt an ‘equity strategy’.61 Paul Ballard, Deputy Director of Public Health, said a next step would be collaboration between the health board and the local authority to devise a ‘new currency’ of ‘health-based indicators’ that would emphasize ‘community resilience’.

GPs and health inequality

The relationship between NHS boards, local authorities and primary care medical practitioners is central to the governance of health affairs in Scotland. Leaders of GPs in Scotland have supported government policy for reducing health inequality. Burns attributes this support to the relative ‘stability of NHS organization over many years’ compared with frequent re-organization in England. For example, the Chairman of the British Medical Association (BMA) in Scotland endorsed the priority accorded to reducing inequality in Burns’ annual report in 2009. Burns, he told the press, ‘is right to focus on children today’. Moreover, ‘work must be done to...reduce inequalities that exist in opportunity as well as in health’.62

Early in 2010, the authors of a BMA report on general practice wrote that the section on reducing inequality ‘received the most consultation’ by members, ‘though there is little consensus on how a reduction...can be achieved’.63 However, the report endorsed joint funding of CHCPs by NHS boards and local authorities for reasons that included the ‘need to actively pursue patients’ in less-affluent areas in order to offer them health assessments and preventive services.

A project called ‘Deep End’, sponsored since 2009 by the Scottish Executive and the Royal College of General Practitioners in Scotland, offers additional evidence about the participation of primary care practitioners in the governance of efforts to reduce health inequality. Deep End convenes 100 GPs whose practices have the highest rates of premature mortality, multiple morbidity and social complexity to discuss how health care could be improved and inequality reduced.

Reports issued by the Deep End project recommend action to address various issues in integrating primary care with related health and social services; for example, ‘Coping with needs, demands and resources’; ‘The GP role in working with vulnerable families’; ‘Social prescribing (defined as practices ‘use of non-medical community resources to respond the needs of their patients’); and ‘Working together for vulnerable children and families’.64 A Deep End ‘manifesto’ in 2011 advocated ‘an integrated package of measures to make best use of NHS resources in serving Scotland’s most deprived populations’.65 Similarly, a conference convened by Deep End in 2012 recommended that GPs should be more involved in the governance of local planning to address health inequality.66 I have, however, only been able to locate anecdotal evidence about the influence of Deep End on policy and practice.

Philanthropy and governance

Despite the commitment of the SNP Government to linking economic development and reducing health inequality, most of my informants did not accord importance to the involvement of business and philanthropy in reducing health inequality. An exception was Andrew Muirhead, a foundation executive who had previously been a banker. He described the collaboration of business, local authorities and the NHS Executive in a venture philanthropy called ‘Inspiring Scotland’ (IS) that is addressing social and health inequality. The initial project (called a ‘fund’) of IS involved 14–19 year olds who were ‘struggling to make a successful transition’ from school to training or employment. In this project, IS supported 22 organizations selected from 177 proposals with contributions of £6.9 million in 2010 from the Scottish Government, companies, corporate and family foundations, and individuals.

Please cite this article in press as: Fox DM, Health inequality and governance in Scotland since 2007, Public Health (2013), http://dx.doi.org/10.1016/j.puhe.2013.04.019
IS’s second and third funds, supported mainly by the Scottish Government, addressed health problems of young children. However, IS has only had limited success. One informant complained that it is ‘creaming money’ from government grants ‘to pay overheads’ and that, despite seeking local approval for projects, it ‘could be much closer to end users’. Muirhead said that IS, as well as other public/private partnerships to reduce health inequality, had been hampered by ‘fragmentation, short-termism and a project mentality’. Nevertheless, he emphasized the ‘cohesiveness of the public, private and non-profit sectors’ in governance.

Conclusion

At the beginning of this article, I asked three questions about how participants in the governance of health affairs in Scotland make and implement policy to reduce health inequality. These questions are similar to those I ask in other jurisdictions. One question is how governance balances competing claims on resources to reduce health inequality (called ‘improving population health’ in most jurisdictions) and to finance health care and related services. The second is how the SNP is linking its twin priorities of reducing health inequality and increasing the rate of economic growth. The third is how research on the socio-economic and biological determinants of health and inequality informs governance.

Balancing competing claims on resources

I have offered evidence about how governance in Scotland has merged policy to reduce inequality with policy to make universal coverage more effective and efficient. This merger is especially evident in the programmes I described that link community-based preventive and social services with primary health care. Officials of the Scottish Executive and of the regions I visited described how providers of social, education and housing services have increased the resources they allocate to co-ordinating with GPs and members of their staff.

Linking economic growth with reducing health inequality

This linkage seems, at least from my interviews and reading, to be mainly a commitment that has not yet been actualized in specific programmes. None of my informants offered examples of action to link economic growth with reducing health inequality. Instead, they made the plausible assumption that reducing inequality and thereby increasing the productive workforce would attract capital investment to Scotland.

Unlike in Scotland, governance in other countries of which I have first-hand knowledge usually separates, even in political rhetoric, policy to address the socio-economic determinants of health from policy to improve access to health care of the highest attainable quality. In Scotland, leading participants in governance told me that economic growth is likely to proceed more rapidly as a result of reducing the adverse effects on health of major changes that occur during the transition to a postindustrial economy; for example, changes in technologies, jobs, markets and investment. Moreover, the commitment to linking policy for access to health care and to reduce health inequality with economic growth seems to be grounded in cross-party commitment to social democracy. This commitment is enhanced by the SNP’s efforts to promote national identity as a prelude to independence.

How research informs governance

In Scotland, unlike in other countries in which I have worked, participants in governance take account of findings from international research synthesized by a single policy maker and his associates. I acquired considerable evidence that the synthesis of findings from neuroscience, social psychology and epidemiology devised and articulated by Harry Burns resonates with many people who have influential roles in governance. It does so, I was told by a variety of informants, because it seeks to explain the experience of Scots rather than of populations more generally.

Leaders of governance in other countries are unlikely to try to replicate policy devised and implemented by their counterparts in Scotland. These leaders know, and considerable research demonstrates, that the governance of each jurisdiction is the major determinant of whether and how policy defines problems and opportunities and responds to contingencies.

However, leading participants in governance of health affairs in other jurisdictions, especially those who make and implement health policy, are likely to be interested in the recent Scottish experience of addressing health inequality. For many years, I have helped to convene meetings attended by policy makers from high-, middle- and low-income countries. This experience offers evidence that leading participants in the governance of health affairs from different jurisdictions are eager to exchange stories about politics and policy. These leaders know that there are no universally applicable policies because the governance of each jurisdiction is different. However, they are interested in considering how to adapt effective policy from other jurisdictions to their local circumstances.

A significant recent and ongoing example of such adaptation has been policy to evaluate competing prescription drugs in order to decide which will be subsidized by public insurance programmes. The recent history of health policy in Scotland has already started to inform conversations between Scottish policy makers and their peers in other jurisdictions. This history is of particular interest to policy makers in other jurisdictions because it provides evidence that a political party can accord high priority to reducing health inequality and win the next election.

Author statements

Acknowledgements

Many people in Scotland made essential contributions to this article. I am, however, solely responsible for how I have interpreted evidence and for its findings and conclusions. I list the people I talked and/or corresponded with in alphabetical order and without titles or degrees: Karen Adam; Kay Barton,
Duncan Booker; Evelyn Borland; Harry Burns; Val Cox; Ron Culley; Linda de Caestecker; Peter Donnelly; Jackie Erdman; Ann Erickson; Derek Feeley; Mark Feinmann; Angiolina Foster; Jean Heron; Adam Ingram; Ade Kearns; Trevor Lakey; Kirsty Licence; Alison McCallum; Michelle McCoy; Alex MacKenzie; Andrew Muirhead; Miles Palmer; Andrew Radley; Shona Robinson; Eileen Stuart; Carol Tannahill; Sara Twaddle; Drew Walker; David Walsh; Graham Watt; Kevin Woods and Steven Wray. I also thank Phil Mackie and Alison Firth of the Public Health Editorial Office for their extraordinary efforts on behalf of this article.

**Ethical approval**

None sought.

**Funding**

Supported by a Robert Wood Johnson Foundation MATCH grant to the University of Wisconsin Population Health Institute.

**Competing interests**

None declared.

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