The Jimmy Reid Foundation

BRIEFING

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Cutting Health Boards

Introduction

The Scottish Government's Programme for Government 2026-31 includes a plan to reduce the current 14 territorial health boards to two. This briefing examines the proposal and its consequences.

Health Boards

NHSScotland consists of 14 regional NHS Health Boards, which are responsible for protecting and improving their population's health and delivering frontline healthcare services. There are also seven Special NHS Boards and one public health body which support the regional Boards by providing a range of important specialist and national services.

The Plan

The Programme only outlines the plan.

> We will **simplify the NHS by replacing the current 14 territorial Health Boards with two Strategic Health Boards** and build on planned reforms to further reduce the number of special Health Boards. Alongside other measures to improve patient experience, including the National Flow Plan, this will deliver more efficient use of resources across Scotland, freeing up more time and capacity for treatment, and improve patient access through more joined up care. It will also support efforts to improve further the integration of health and social care services.

We know that Health Boards, led by Glasgow and Lothian, have been working on this for some time, and it was hinted at in the SNP manifesto. Scottish Labour has argued for three health boards for many years, though without much detail. The plan is for an east/west split.

This is not the first plan to cut the number of health boards. A Tory government plan to reduce the number of health boards to three or four existed prior to devolution, but did not progress from the Minister's desk. At the time there was a move to very large (regional) acute hospitals in England. Larger health boards in Scotland might have assisted this process. However, the politics of closing local hospitals was seen as too big a challenge, and it was also slowed down in England.

Efficiency Savings

The main driver of this proposal is to make savings that can address the coming budget shortfall and/or provide more resources for patient delivery.

Senior management posts should be reduced, with fewer executive board members (typically five per board) and a rationalisation of executive directors (typically nine per board). There will be modest savings from having fewer non-executive members, who receive £ 16,224 for a typical 52-day commitment per year.

However, many executive directors will still need to manage the specialist services they run in each geographical area, and larger health boards will require a sub-structure for the functions managed by executive board members. There should also be savings in office space and facilities management, although this will be longer-term as the buildings are sold off. There will also be significant relocation and voluntary redundancy costs as staff at all levels move to new locations or are redeployed. Travel costs in the large areas to be covered will rise significantly. The history of this type of public service reorganisation shows that the savings are, at best, medium-term.

In addition, long experience of this type of reform shows that it leads to management paralysis in the run-up to change, and that it takes several years for the new structure to settle. That is not a reason to avoid change, but it is important to be realistic about how quickly any benefits will be achieved.

Governance

NHSScotland is already highly centralised, with no local democratic accountability. Having two health boards effectively removes local input from service delivery. An East/West split is largely an administrative convenience and bears little relation to the services delivered, although some established clinical networks cover parts of these areas. The government might consider establishing engagement mechanisms, as appears to be the plan in local government.

Other European countries have more decentralised systems. For example, Spain and Italy have moved to regional governance. Sweden runs services from 21 counties. In Norway, community services are run by much smaller local

authorities than ours, while acute services are managed regionally or nationally.

The Programme is even vaguer on special Health Boards. Eight boards run specialist national services like NHS24 and the Scottish Ambulance Service. Merging them into one special health board would be largely cosmetic, as the individual services would still require service heads. There may be marginal savings from sharing central services, but again, these would be, at best, medium-term.

Community services

It is possible to run acute hospital services from larger health boards. Three or four would enable a reasonable management scope, retain some local input, and support a coherent plan for specialist services.

The challenge is community services, GPs, pharmacy, allied health professions and the all-important link to social care. Managing these in remote regional health boards was not considered viable in the pre-1997 paper, and similar considerations apply today. We now have 31 health and social care partnerships, the latest of some 14 different initiatives to integrate local health and social care services since the 1970s. This means that reducing to two health boards requires a decision on the governance of local health and care services.

There are three broad options.

1. Retain the current structure and create a community management structure in each new regional health board. This could work if management were genuinely devolved, although the NHS management culture would find this challenging.
2. Turn the existing structures into corporate bodies employing their own staff. Currently, workers remain employed by either local government or the NHS, as well as voluntary and private sector contractors. Most senior managers in the health and care partnerships favour this option. However, politically, this would involve creating 32 new quangos and all associated costs. Both NHS and local government trade unions are unlikely to be supportive.
3. Devolve NHS community services to local government. This model operates in European countries, particularly Nordic states. It ensures integrated and local accountability, although this would be less evident in Scotland, which has the largest councils in Europe. Countries that do this accept that it remains difficult to move resources from regionally managed acute services to community services. Every government in Scotland has also aimed to achieve this, and all have failed. The NHS trade unions would oppose moving NHS staff into local government.

Related Reforms

The programme briefly references social care reform. After the National Care Service (NCS) debacle, the government is now proposing to "use these next three months to engage with local authorities, trades unions, and healthcare and service providers to reach agreement on reform of social care." However, the FM has indicated that he wants the NHS to lead social care. Effectively, a new version of the centralised NCS.

It will be a busy three months because the programme also says, "Over the next three months we will convene a dialogue with partners across Parliament, local government, and beyond about the future of local governance in Scotland." This clearly indicates that the reform will involve some form of regional governance (although thankfully without mayors/provosts). There is no indication that local councils will reflect actual communities as they do in most of Europe. It appears the best they might achieve is stronger engagement. It seems unlikely that the 'means to articulate their priorities' involves democratically elected councils in communities of place. We set out why this is important in our recent paper 'The Policy of Place'.

The exception to further centralisation is the island authorities, with the "exploration of the Single Authority Model." This idea has been floated many times since devolution, and might deliver something close to our Option 3 in relation to community services. The question is, if it can be done on the islands, why not everywhere else?

Conclusion

Public service reform is rarely as straightforward as it initially looks. Reducing the number of health boards could deliver financial savings, although not quickly. However, it also requires other structural decisions, particularly around social care and local government. Restructuring to cut costs ignores the key point of the Christie recommendations – focus on outcomes. More centralisation is rarely the right solution.

Jimmy Reid Foundation

The Jimmy Reid Foundation is a think tank which brings together different voices from across Scotland to make the case for economic, environmental, political and social equity and justice in Scotland and further afield.

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