DECISIONS AND RESOURCES IN THE

NATIONAL HEALTH SERVICE

IN SCOTLAND:

A Case Study of Two Health Boards

by

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Ph D Degree
University of Edinburgh
1979
DECLARATION

I hereby declare that this thesis, submitted for the degree of Ph D, has been composed by me and that the work is fully my own.
CONTENTS

Diagrams iv
Tables iv
Acknowledgements v
Abstract vi

Chapter 1 INTRODUCTION 1
1.1 Background 2
1.2 Study Aims 13
1.3 Overview of NHS 17
1.4 Plan of Thesis 31

PART 1
THE NATIONAL HEALTH SERVICE: Background to Case Study

Chapter 2 THE NATIONAL HEALTH SERVICE IN SCOTLAND 36
2.1 The Scottish NHS: 1948-1974 43
2.2 Pressures for Reform 49
2.3 Conclusions 70

Chapter 3 THE REORGANISED NHS IN SCOTLAND: A Review of the New Structure 73
3.1 The Proposals 74
3.2 The Structure 82
3.3 New Influences on Decision-Making 92
3.4 Reactions to Reorganisation 108
3.5 Conclusions 121

PART 2
THEORETICAL BASIS AND METHOD

Chapter 4 THE THEORETICAL BASIS 126
4.1 A Frame of Reference 126
4.2 Decision-making & Non-decision-making 131
4.3 Theories of Decision-making 138
4.4 The Application of Theory to the Case Study 155
4.5 Conclusions 167

Chapter 5 THE CASE STUDY APPROACH 170
5.1 Disadvantages 172
5.2 Advantages 174

Chapter 6 RESEARCH METHOD 180
6.1 Field Entry 180
6.2 The Changing Focus of the Case Study 191
6.3 Data-gathering Techniques 195
## PART 3

### THE CASE STUDY

<table>
<thead>
<tr>
<th>Chapter</th>
<th>THE POLICY TRIAD: DRAMATIS PERSONAE (1)</th>
<th>HEALTH BOARD MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>7.1 Health Boards: Appointment v. Election</td>
<td>216</td>
</tr>
<tr>
<td></td>
<td>7.2 Composition &amp; Functions of Health Boards</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>7.3 Organisation of Health Boards</td>
<td>243</td>
</tr>
<tr>
<td></td>
<td>7.4 Demands on Health Board Members</td>
<td>258</td>
</tr>
<tr>
<td></td>
<td>7.5 Relationships between Health Board Members &amp; Chief Officers</td>
<td>262</td>
</tr>
<tr>
<td></td>
<td>7.6 Coping Strategies</td>
<td>267</td>
</tr>
<tr>
<td></td>
<td>7.7 Comment</td>
<td>277</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter</th>
<th>THE POLICY TRIAD: DRAMATIS PERSONAE (2)</th>
<th>HEALTH BOARD OFFICERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>8.1 Area Executive Group (AEG)</td>
<td>282</td>
</tr>
<tr>
<td></td>
<td>8.2 District Executive Group (DEG)</td>
<td>298</td>
</tr>
<tr>
<td></td>
<td>8.3 Consensus Management</td>
<td>321</td>
</tr>
<tr>
<td></td>
<td>8.4 Sub-District Management (Sectors)</td>
<td>338</td>
</tr>
<tr>
<td></td>
<td>8.5 Comment</td>
<td>351</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter</th>
<th>THE POLICY TRIAD: DRAMATIS PERSONAE (3)</th>
<th>ADVISORY STRUCTURE (PROFESSIONAL &amp; CONSUMER)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>9.1 Medical Advisory Structure</td>
<td>356</td>
</tr>
<tr>
<td></td>
<td>9.2 Nursing Advisory Structure</td>
<td>359</td>
</tr>
<tr>
<td></td>
<td>9.3 Paramedical Advisory Structure</td>
<td>362</td>
</tr>
<tr>
<td></td>
<td>9.4 Local Health Councils (LHCs)</td>
<td>367</td>
</tr>
<tr>
<td></td>
<td>9.5 Comment</td>
<td>383</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter</th>
<th>THE BUDGETARY PROCESS (REVENUE ALLOCATIONS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>10.1 Arrangements for Allocation of Resources</td>
</tr>
<tr>
<td></td>
<td>10.2 Illusion of Central Control</td>
</tr>
<tr>
<td></td>
<td>10.3 Comment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter</th>
<th>DETERMINATION OF POLICY: DEVELOPMENT FUND ALLOCATIONS (YEAR 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>11.1 Development Lists</td>
</tr>
<tr>
<td></td>
<td>11.2 The Function of the AEG</td>
</tr>
<tr>
<td></td>
<td>11.3 The Districts' Dilemma</td>
</tr>
<tr>
<td></td>
<td>11.4 AEG: round two</td>
</tr>
<tr>
<td></td>
<td>11.5 Professional Advisory Committees</td>
</tr>
<tr>
<td></td>
<td>11.6 Policy and Resources Committee</td>
</tr>
<tr>
<td></td>
<td>11.7 Aftermath</td>
</tr>
<tr>
<td></td>
<td>11.8 Beta: Development Funds (Year 1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter</th>
<th>DETERMINATION OF POLICY: DEVELOPMENT FUND ALLOCATIONS (YEAR 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>12.1 Development Plateau</td>
</tr>
<tr>
<td></td>
<td>12.2 The Scope for Savings</td>
</tr>
<tr>
<td></td>
<td>12.3 The Way Ahead</td>
</tr>
<tr>
<td></td>
<td>12.4 Development Funds - Allocation Process</td>
</tr>
<tr>
<td>Chapter 13</td>
<td>THE ALLOCATION PROCESS: AN ANALYSIS</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>13.1</td>
<td>Importance of DF</td>
</tr>
<tr>
<td>13.2</td>
<td>Constraints (1) External</td>
</tr>
<tr>
<td>13.3</td>
<td>Constraints (2) Internal</td>
</tr>
<tr>
<td>13.4</td>
<td>Coping Strategies</td>
</tr>
<tr>
<td>13.5</td>
<td>The Scope for Innovation</td>
</tr>
<tr>
<td>13.6</td>
<td>An Assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 14</th>
<th>CONCLUSION</th>
<th>622</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td>Conclusions (1) The Case Study</td>
<td>622</td>
</tr>
<tr>
<td>14.2</td>
<td>Conclusions (2) General Comment</td>
<td>642</td>
</tr>
<tr>
<td>14.3</td>
<td>Implications for Policy</td>
<td>663</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Notes</th>
<th></th>
<th>673</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix I</td>
<td>Research Project - Statement of Intentions</td>
<td>729</td>
</tr>
<tr>
<td>Appendix II</td>
<td>List of Interviews</td>
<td>731</td>
</tr>
<tr>
<td>Appendix III</td>
<td>Specimens of Aide Memoires for Interviews</td>
<td>733</td>
</tr>
<tr>
<td>Appendix IV</td>
<td>Covering Letter &amp; Questionnaire to Health Boards</td>
<td>737</td>
</tr>
<tr>
<td>Appendix V</td>
<td>Abbreviations</td>
<td>745</td>
</tr>
</tbody>
</table>

Bibliography | 748 |
1. Plan of Thesis 29
2. National Health Service (Scotland) 1948-1974 46
3. National Health Service Reorganisation Scotland 1974 78
3a. National Health Service Reorganisation England 1974 79
4. Map of Principal Decision Actors in Development Fund Allocations 182
5. Health Board Committee Structures
   1. Alpha 247
   2. Beta 247
6. Health Board - Organisation Charts for Principal Departmental Functions
   1. Administration 283
   2. Finance 283
   3. Medical 284
   4. Nursing 284
7. Health Service Expenditure in Scotland 389
9. Annual Cycle for Allocation of Development Funds 408

6.1 Health Boards: Approximate Population & Revenue Allocations 1975/76 183
7.1 Breakdown of Health Board Membership 222
9.1 Breakdown of LHC Membership (Alpha) 370
9.2 Breakdown of LHC Membership (Beta) 372
11.1 Development Lists (Alpha): Total Submissions & Priority Categorisation (Year 1) 413
13.1 Percentage Distribution of Revenue Expenditure on Hospital, Community & Primary Care Services 1974/75-1977/78 (Alpha) 613
13.2 Revenue Expenditure - Percentage Increase 1974/75-1975/76 (Alpha) 613
13.3 Percentage Distribution of Revenue Expenditure on Hospital, Community & Primary Care Services 1974/75-1977/78 (Beta) 615
ACKNOWLEDGEMENTS

The case material in Part 3, Chapters 7 to 12, which forms the core of the thesis, is based on research carried out between 1975 and 1977. The research involved numerous individuals in the two health boards selected for study, including members, officers and representatives of various professions. They tolerated my presence and inquiries with patience and good humour. I am most grateful to all of them for their cooperation and generous hospitality and to the ten other health boards which responded so readily to my questionnaire.

Thanks must go to the Social Science Research Council without whose financial support the research would not have been possible. I am, of course, indebted to my two supervisors, Susan Sinclair (Department of Social Administration) and Charles Raab (Department of Politics), for their guidance and support. Both read through, and commented on, early working papers and a first complete draft of the thesis. Drummond Hunter, a former Board of Management Group Secretary and Treasurer, and presently Secretary, Scottish Health Service Planning Council, commented on an initial draft and the rare combination of experience and knowledge of the NHS plus enthusiasm and vision was invaluable during countless exchanges. I also wish to express my appreciation to those who provided opportunities to discuss my research at various stages of completion. In particular, thanks go to Rex Taylor, MRC Medical Sociology Unit, University of Aberdeen; Kenneth Boyd, Edinburgh Medical Group; and Alan Davis, Department of European Languages and Institutions, Cranfield Institute of Technology. Needless to say, none of the above is responsible for any faults or errors in what follows.

I am grateful beyond words to Peggie Hunter who, despite numerous competing pressures, has coped admirably with a lengthy and, at times, complex manuscript. Finally, I reserve a special thanks to my wife, Mairi, who has lived with the thesis for as long as I have. She has not only helped directly through the provision of essential support services and through checking the final typescript but, more important, she has been a vital moral support throughout. Her encouragement and devotion have been indispensable.

David J Hunter
March 1979
ABSTRACT

The thesis reports on a two-year study which looked at decision-making in two Scottish health boards. The research was prompted by: (1) a dearth of knowledge concerning the dynamics of decision-making in the National Health Service (NHS) at local level; and (2) a desire to understand the factors at local level which might help to explain the persistence of resource imbalances between different sectors of health care despite numerous attempts to remove them.

The case study, which forms the core of the thesis, has two aims: (1) to describe decision-making in the two boards in the area of development fund allocations (ie growth monies) in order to discover the process by which priorities are set; and (2) to provide insights into the operation of the management structure introduced when the NHS was reorganised in 1974. Reform was largely about improving the rationality of decision-making and the case study aims to show what this involved in practice. Rational and incremental theories of decision-making are reviewed for their usefulness in understanding events, although no single theoretical perspective is favoured over others.

The main study findings were: (1) that, contrary to much popular opinion, decision-making in the NHS is, to a significant degree, decentralised - both boards possessed a large measure of influence over the services they provided; (2) that, despite this discretion, the emphasis in allocation decisions was on policy maintenance rather than on policy change; (3) that part of the explanation for this resided in a number of constraints, both external and internal, operating on decision-makers; and (4) that a number of coping strategies were adopted by decision-makers in order to facilitate the task of allocating resources and to come to terms with the uncertainty inherent in the decision-making environment. The research also revealed a number of tension points arising from the management structure, many of which served to reinforce the obstacles to change through development fund allocations.
Chapter 1

INTRODUCTION

This thesis is about decision-making in the National Health Service (NHS) in Scotland. It addresses itself, in particular, to financial decisions involving more strategic levels of choice than is the case with simple routine decision-making. Decision-making of this strategic type tends to be linked with the term 'policy-making'. Yet the decision-making activities, which form the empirical core of the present research, are not examples of policy-making directed towards the improvement of, say, geriatric services or acute services as functional groupings, ie macro policy-making. As between routine decision-making at one extreme, and macro policy-making at the other, the decision processes with which this research is concerned fall within the category of middle-range decision-making. Of course, the outcomes of middle-range decision-making at health board level can have an impact on broader policy-making activity. More often, middle-range decision-making is a substitute for macro policy-making.

The research is essentially qualitative and takes the form of a case study, carried out over a period of approximately two years, of the operations of two Scottish Health Boards in the area of development fund allocations. This introduction outlines: (1) the background to the research (ie the reasons for undertaking it); (2) the main
purposes of the research: (3) the NHS environment within which the research is located; and (4) the form taken by the thesis in the following chapters.

1.1 Background
The research was prompted by two somewhat different considerations: (1) the absence of studies describing what actually happens within the field authorities comprising the NHS in Scotland; and (2) the persistence of resource imbalances (a) as between different sectors of health care; (b) as between different health authorities; and (c), what is more pertinent for present purposes, within health authorities. Despite attempts by successive governments to redress these imbalances, acute services continue to receive the bulk of available resources at the expense of the 'Cinderella' sectors (i.e. geriatrics, the mentally ill and the mentally handicapped) which continue to lag behind, and some areas clearly have more resources than others, just as some districts have more than others.\(^{(2)}\)

There are few case studies in Britain of how administrators go about their work. This is evident throughout the field of public administration,\(^{(3)}\) but it is particularly noticeable in the NHS, and especially noticeable in Scotland. Most work on public administration in Britain has been content to describe what institutions are, rather than what they do. A recent example of this formal approach is Levitt's book on the reorganised NHS.\(^{(4)}\) Although valuable, studies of this kind make no attempt,
often deliberately, to come to terms with the dynamics of decision-making and with the political realities involved. Instead they centre on structural questions, such as the size of authorities and the distribution of powers within these authorities, rather than on questions of process and of the actual behaviour of people within formal structures. The literature on the dynamics of decision-making and on the political realities which are inseparable from decision processes is scanty. Books on public administration, as Ridley has noted,

`...embody little research into what actually goes on inside the administration ... The administration ... is the box in which inputs are actually translated into outputs ... The way the box is organised, its pattern of work and communication system, for example, is bound to affect (the policy process). (5)`

It is fair to say that, overall, the study of decision-making, from an organisational/political perspective, is more advanced academically in America (with the exception of some British examples cited below). Recent decades in the United States of America have witnessed a steady stream of decision-making studies, all aimed at unravelling and elucidating the complex processes involved in reaching decisions. Examples include studies of foreign policy decision-making,\(^6\) a study of decision-making in committees;\(^7\) studies of budgeting decisions;\(^8\) and, more recently, a study of the Medicare programme,\(^9\) and a case study of the decision process surrounding the Cuban Missile Crisis in 1963.\(^{10}\)

Ridley argues that 'one of the facts holding back
researchers (in Britain) ..... is that our administration is nowhere near as open as the American'. Nevertheless, a number of studies in recent years have attempted to correct this imbalance between the two countries and, at the same time, overcome what Stanyer refers to as 'the legalism and institutionalism' that have dominated studies of government and public authorities, particularly local government. Stanyer's approach to understanding local government involves perceiving local authorities as individual miniature political systems in their own right, each with its own distinctive character. The policy-making and budgetary processes in local authorities are just beginning to receive attention. For example, work is in progress at the Institute of Local Government Studies. Less recent, but still a classic, is the study by Friend and Jessop in which an attempt is made to describe the decision-making process in local government by presenting a case study of one local authority. This study was severely criticised by Power on the grounds that insufficient attention had been paid to the political structure and its processes. The study, maintained Power, had a 'strong enlightenment flavour'. There was 'a belief in the rationality of man, and a faith that problems must fall before rationality'. A further book by Friend, Power and Yewlett attempted to remedy these deficiencies by taking political factors into account in the theoretical framework. The book's central concern was with the inter-organisational (or 'inter-corporate')
dimension of the public planning process, the case material being drawn in the main from observations of decision-making in relation to different aspects of the planned expansion of a small English town.

Education has received a reasonable amount of attention. For example, Kogan's book\(^{(18)}\) has been widely acclaimed as one of the best studies of the processes and problems of decision-making in politics. In his more recent book\(^{(19)}\) he attempts to take this analysis further by looking at policy movements in education between 1960 and 1974. On a broader, national level there is the study by Heclo and Wildavsky\(^{(20)}\) which describes in fascinating detail the inner workings and cultural milieu of the higher civil service, and the role of civil servants in decision-making.

Although there have been a few studies of social policy-making\(^{(21)}\) when it comes to the NHS there is less evidence of academic interest in organisational and/or political issues, especially at a local level. While some research has been conducted on the professional/bureaucratic dilemma within health care systems\(^{(22)}\) most medical sociology has been confined to definitions of disease and to studies of doctor/patient relationships, and organisational and political questions relating to the planning and delivery of services have been neglected. Illsley\(^{(23)}\) recognising this neglect, argues for a shift in attention from decision-making in clinical settings to decision-making in administrative structures. Support for this comes from an SSRC advisory panel on health and health
policy. In a report(24) this panel suggests that the development and implementation of policy is one of three main research areas (the others being patterns of health care and evaluation). The panel points out that, since health policy-making is the product of complex interaction between groups both within and outside the decision-making system,

a useful step for research would be a mapping exercise designed to unravel some of the complexities of health care provision and to distinguish between the different viewpoints - political, administrative, professional, scientific, interest and client group. (25)

In its report the panel claims that 'research can usefully identify the points of influence in the system and the sources of inertia, tension and resistance to innovation'.

The fact that there is a dearth of studies in Britain aimed at understanding what goes on in the NHS (the 'black box' to which Ridley refers), is one of the principal reasons for embarking on the present research. What sorts of decisions are made? Why? Who is involved in them? How much autonomy do health boards possess? Is there constant central government interference? How are scarce resources allocated? How are choices made between competing demands? The list of questions is endless. Each one could form the subject of an entire thesis. Yet at present we have few answers to any of them. In particular, there remains a great deal of ignorance about decision-making processes at a local level, within health authorities. And, while this is true of Britain as a whole, it is especially true of Scotland, where little or
no research has been undertaken and where, in consequence, crucial gaps in our knowledge are even more apparent.

In England, some work is in progress on various aspects of the NHS at Brunel University (Health Services Organisation Research Unit), Hull University (Institute for Health Studies), and at Leeds University (Nuffield Centre for Health Services Studies). There have also been some studies of NHS policy-making on a national level; but these have only served to emphasise the paucity of data about what goes on within local health authorities. Obviously, analyses from both central and local perspectives are necessary and ought to complement each other, but there are sound reasons for shifting the emphasis to the local arena. Kogan suggests that social scientists in this country are far too interested in large-scale decision-making at the centre to come to grips with the fine grain of social systems and what they have to do. Such questions as the structure of the delivery system, the ways in which different values can be stated in the humdrum institutions that make up the welfare state are the real base line for policy analysis.

These are 'the sites of the real social action'.

Scotland merits separate attention because there are significant differences between the organisation and administration of its Health Service and that of England. To the author's knowledge, there are only two research projects which are at all concerned with the organisational and political aspects of decision-making processes at the local level in the NHS in Scotland. One is a study of
the different interest-groups within a chosen health board.\(^{(32)}\) The other has been undertaken by the Institute of Operational Research (IOR) under the auspices of the Scottish Home and Health Department (SHHD). The focus of the latter study has been primarily on the development of a planning system for the Health Service in Scotland in order to improve decision-making both at the centre (SHHD) and at area level (health boards). As a preliminary, the IOR work involved some description of existing decision-making processes; but, if one is to judge by published output, this has been on rather a limited scale.\(^{(33)}\) If the primary aim of the IOR research has been to increase the rationality of decision-making within the NHS,\(^{(34)}\) a thorough appreciation of existing procedures would appear to be an essential prerequisite (see below).

If virtually nothing was known about decision-making at the local level in the NHS before its reorganisation (in Scotland only the Farquharson-Lang report\(^{(35)}\) provided some useful information on the administrative practices of hospital boards), then even less is known about it now. Although reorganisation has prompted several studies which are investigating the operation of the new structure (such as the Humberside research project),\(^{(36)}\) it will be some time before the findings of many of these studies emerge; and with the exception of the two projects referred to in the preceding paragraph, these studies are confined to England.
What is perhaps most striking about the NHS reorganisation, as evidenced by its adherence to a rational-efficient paradigm based on a 'business management' approach, is the fact that the whole emphasis is on what should be done, without any attempt being considered necessary to see what is done. It is interesting to note that the reorganisation (in the making for almost ten years) was carried through without any study of existing decision-making processes having been commissioned. This is characteristic of the British approach to administrative reform and can be seen at work in other areas like local government and central government. In view of the major changes which were put in train, however, in the NHS, it was surely a significant and, indeed, an astonishing omission. It is not surprising that Stanyer and Smith are critical of administrative reform in Britain between 1966 and 1976.

Neither the student of public administration nor the citizen ... can be satisfied with the present state of affairs. The processes of investigation, analysis and advice about the machinery of government do not justify the words used to commend them when, for instance, a Royal Commission is created. The cynical view is undoubtedly realistic; reform arises from political demands or political expediency, and the language of rational discovery is a facade.

Relevant knowledge on the realities of decision-making is necessary and indeed indispensable, since sensible reforms (one can argue about what these might be) must depend on knowledge of the world as it is, just as much as on knowledge of the world as it ought to be. In the case of
the NHS, until a more adequate description is developed of what actually happens in health authorities, where policy is largely formulated and implemented (see below), and until something is known about the 'existential situation' in which participants find themselves, proposals for reform will continue to be based on inadequate understanding. This does not augur well for their success.

The second concern which prompted this research was puzzlement at the persistence of resource imbalances as between different sectors of health care, as between different health authorities and particularly within health authorities, and a desire to find out what influences and constraints operated upon decision-makers to account for these inequities. The existence of these imbalances is well known and a desire to eliminate them was one of the chief reasons for reorganising the NHS. Some research has been carried out in this area but its scope has been limited and it has not investigated, in any depth, decision-makers' own perceptions of the issues involved and the difficulties which arise from the environment within which they operate. For example, do the imbalances which exist between services arise from the power relations within health authorities? Do they emanate from a desire not to disturb vested interests? Or do they exist as a result of the uncertainty of the environment: decision-makers simply do not know what to do or how to do it? Heclo has written, 'social policy-making is about puzzlement as well as power; it entails both knowing and deciding'. It may be that in an
uncertain environment, administrators strive for stability and order instead of encouraging change or innovation, and that this accounts for the tendency to maintain the status quo. Schon\(^{(44)}\) has termed this reaction 'dynamic conservatism' (ie people 'fight like mad to stay where they are'). It is not simply a question of medical politics dictating what decisions emerge, although undeniably such activity is of relevance. Possibly, the process is more subtle than crude power politics for the reasons Heclo states. The NHS decision-making environment is, or can be, uncertain. Preventive care illustrates this. No one is quite sure what preventive care means or involves in the way of specific policies and services. Is a health education programme worth initiating? Or should mass screening programmes be started? How does one measure the return on investment? The entire preventive field is riddled with such questions. Answers may be forthcoming one day, but meantime administrators and others are involved in what might be termed 'cautious groping'. In the present research it is a question of exploring in depth some of the dilemmas which face local decision-makers in the NHS.

An interesting point is raised when one discusses the imbalances in service provision that occur within health authorities. This is to the effect that decision-making in the NHS is far more decentralised than is sometimes argued. For example, Enoch Powell\(^{(45)}\), when Minister of Health, maintained that the NHS was over-centralised,
whereas Richard Crossman,\(^{(46)}\) when he was Secretary of State for Health and Social Services, believed quite vehemently that the centre lacked sufficient control over health authorities. He describes how difficult it was to shift resources from acute services to those in the 'Cinderella' sectors of health care. Klein\(^{(47)}\) shares Crossman's views. The NHS is run by the centre on a loose rein, and is, in fact, a good example of decentralised decision-making. This is not to say that the centre never interferes authoritatively with health authorities but it rarely does so, or its attempts to do so tend to be distorted or suborned. Reorganisation of the NHS was, in large part, an attempt to improve the centre's ability to decide overall priorities and thereby influence the day-to-day decisions taken by the field authorities. But health authorities possess a large measure of administrative influence over the services which they provide.

Similar myths about centralisation and the erosion of local autonomy surround the relationship between central and local government. Whereas the report of the Layfield Committee on Local Government supports this orthodox view, some observers, including Rhodes\(^{(48)}\) believe that it is misleading. There is a distinction between the controls central government has over local government and their actual operation. 'Legal forms and reality differ markedly'. What needs to be recognised is the political dimension, '... complex interactions take place within a
system of administrative politics ...'(49) Just as local authorities should be seen as political entities, with shifting routines and allegiances, so should health authorities be seen as political arenas with shifting routines and allegiances.

1.2 Study Aims
The case study has two aims, which will be elaborated upon in subsequent chapters.

(a) The study is primarily a description of decision-making in two health boards. It is concerned with discovering the processes by which certain policy (or middle range) decisions are made in the NHS at the local level, by seeking answers to questions like the following: how are scarce resources allocated? Who is involved in these decisions? How are choices made between competing demands? Is there a hierarchy of power or influence? What information is used in the discussions surrounding the decision-making process? In short, it is the intention of the case study to go some way towards eliminating some of the ignorance identified earlier, by untangling the processes involved in reaching certain types of resource-allocation decisions in the NHS. It
proceeds by identifying the constraints and the political forces which help to shape decisions.

(b) The study, through its focus on decision-making, is a profile of the reorganised NHS in Scotland. It provides some insights into the operation of the new management structure within health boards through its analysis of certain decision processes within this structure. It is not intended that the case study should represent an evaluation of the new structure, nor, indeed, could any single case study form the basis for such an evaluation. The study offers no more than a low-level assessment of the reorganisation in order to present some tentative conclusions on its impact on the decision processes observed.

In the case study a particular area of the budgetary process is examined. The greater part of the funds allocated to each health board is already earmarked for existing commitments. Although theoretically these funds could be put to different uses, in practice they are not. The budgets remain fixed. In the jargon, there are no 'zero-base reviews'. The case study focuses upon the 'new' money which a health board receives annually from the SHHD for developing the Service. Development funds
(DF) enable a health board to develop new services, improve existing ones, or to change direction as a result of a new emphasis having been placed on certain services. It is in connection with the allocation of these funds that one may best observe the processes which are involved in deciding how the service is to be developed. Particularly interesting are the sorts of calculations and tactics that are deployed in discussions concerning the allocation of DF. In short, whatever the significance of the substance of any decision, it is the process of decision-making which is of primary concern to the present research.

In addition to its intrinsic value, focusing on a specific area of decision-making also affords the researcher entry to the organisation in which he has an interest. Although the case study is concerned with a narrowly defined area of decision-making, it is fair to say that similar factors and relationships apply, to a greater or lesser extent, to other areas of decision-making involving priorities and choices, eg capital building schemes. Often the same participants will be involved in these decisions, and similar considerations will be taken into account.

Focusing upon DF is a means of entering the management structures of health boards in order to observe the processes and interactions that are going on within these structures. To this extent, DF are an example of the 'tracer' technique, whereby a researcher selects a decision process and follows it through a chosen
organisational setting as a way of gaining access to, and an understanding of, the organisation.

Apart from the tracer technique approach, clearly it is not possible or practicable for one researcher to observe the entire decision-making process in a health board. Therefore, it is sensible to select a specific area of decision-making on which to concentrate one's efforts. The vantage point offered by a concentration on budgeting decisions offers a useful and much-neglected perspective from which to analyse the making of policy in health care.

Wildavsky\(^{(50)}\) claims that the task of allocating money can explain, or help to explain, how people at various levels in an organisation cooperate, bargain, and negotiate. The struggle for money is a pervasive and informative operation about what goes on in an organisation. 'Budgeting is concerned with the translation of financial resources into human purposes'.\(^{(51)}\) Since funds are limited and have to be divided in one way or another, the budget becomes a mechanism for making choices among alternative expenditures. 'Human nature is never more evident than when men are struggling to gain a larger share of funds or to apportion what they have among myriad claimants'.\(^{(52)}\) If politics is regarded as the conflict over whose preferences shall prevail in the determination of policy, then the budget records the outcome of this struggle. 'The budget lies at the heart of the political process'.\(^{(53)}\) This, in turn, can reveal much about the administrative structure of an organisation - its operation and the interaction among its
component parts. A study of resource-allocation decisions can indicate what pressures make for policy change or for policy maintenance\(^{(54)}\) and whence these originate.

1.3 Overview of NHS

Before outlining the plan of the thesis, it is necessary to consider briefly the NHS as a whole in order to identify more precisely the context in which the case study is located.

The NHS is a distinctive type of formal organisation which deviates somewhat from the Weberian model of bureaucracy.\(^{(55)}\) What is unique about it is that it is a split organisation, with a bureaucratic component and a professional component.\(^{(56)}\) It is the nature of this split organisation which underlies many of the management problems and tensions in the NHS, before and since reorganisation, and which hinders the bringing about of a more equitable use of resources between different sectors of health care.\(^{(57)}\)

The type of organisation found in the NHS and the distribution of power and authority within it is deeply affected by the doctor's special relationship to his patients (ie the concept of clinical autonomy, arising directly out of the nature of the doctor-patient relationship, which has been enshrined in all official reports concerned with the organisation of the NHS, from its inception in 1948 to its reorganisation in 1974). There are other so-called 'professional' groups in the NHS, notably nurses, but the medical profession has a unique
authority. (58) Rowbottom (59) has written, 

the position of doctors ... presents a fascinating, and possibly unique, situation to any student of organisation. Never have so many highly influential figures been found in such an equivocal position - neither wholly of, nor wholly divorced from, the organisation which they effectively dominate.

What constitutes a profession will not be the subject of lengthy discussion here. Suffice it to say that the study of professions to date has, with one or two notable exceptions, tended to accept unquestioningly professionals' own definitions of themselves. (60) There has been no attempt to understand professional occupations in terms of their resources of power and the ways in which they use them. The resources of power of any profession depend largely on the esoteric character of its knowledge or expertise, as this affects the degree of autonomy and influence which a profession possesses. Knowledge itself does not give special power, but rather the fact of organised occupations which have exclusive access to such knowledge. It is in this sense that the professions should be viewed as inseparable from political processes. Knowledge and skill are claimed by a group to advance its interests. Claims to such expertise are thus unlikely to remain neutrally descriptive. They function as professional ideologies. (61) These ideologies can be a function of crude self-interest, or they can be seen as natural outcomes of a deep commitment to the value of the work a
profession does. This orientation helps to explain why each profession tends to see the world in terms of its own conception of problems and solutions, and why in the political arena each tries to argue for more resources as a way of advancing the general good. This latter point emerges strongly in the case study presented in Part 3.

A feature of the NHS is the interaction and interplay between the deliverers of health care (primarily the medical profession, but other occupations are also involved), the administrators (lay and professional) who control the resources and who are responsible for the running of the Service, and the health board (the governing body which is composed largely of lay members). The relationship between the medical profession and administrators in the management of the NHS is of particular interest since the aims and objectives of each group are very different: doctors insist upon complete clinical freedom to treat every patient in the manner that they individually see to be in the patient's best interests, and they see themselves as being accountable only to the patients whom they serve and to their own conscience; administrators, on the other hand, are concerned with the operation of the NHS as a whole rather than with the specific needs of individual patients, and they see their purpose as one of achieving a more economic, efficient and effective use of limited resources. The relationship between these two groups is crucial in the operation of the NHS. Is it a relationship marked by open conflict and suspicion, which one might
expect it to be judging by doctors' public views of administrators, or is there much more cooperation and understanding than one is sometimes led publicly to believe? In between these polar extremes lies a course of peaceful coexistence. Which conforms most closely to reality?

Four aspects of the medical profession's influence on the NHS deserve consideration here (these are not dealt with at any length in the case study, but form part of the background to it):

(a) the medical profession and clinical autonomy;
(b) the authority of the medical profession in relation to other professions;
(c) the extent to which one medical profession can be said still to exist;
(d) the relationship of the medical profession(s) to the management of health services.

(a) Much of the medical profession's influence is derived from the rather nebulous concept of clinical autonomy. Administrators have no right to direct in the area of care and treatment, they can only discuss and persuade (of course, discussion and persuasion as management tools are more and more becoming the norm in negotiations with all occupations; nevertheless the medical profession occupies a special position). "Doctors to date have for the most part been given blank cheques to make
whatever demands upon the system that they individually see fit.\(^{62}\) It is at this interface, where the immovable object of clinical autonomy meets the force of resource constraints, that the most interesting characteristics of decision-making in the NHS may be observed. Here, the groups of decision-makers which form a **policy triad** (ie health board members (governing body), officers, and advisory bodies representing the health care professions and consumers) converge to negotiate, persuade and bargain. It is at this stage that conflicts can occur and compromises may have to be forged.

(b) The authority of the medical profession in relation to other health care occupations is another fruitful area for study. Do such relationships strengthen the medical profession's power and autonomy, or do they weaken it by acting as constraints upon it? Is the hegemony of the medical profession at an end (see below)?

(c) In addition to **inter-professional** relationships, **intra-professional** rivalries are now a major feature of the medical profession and of medical politics generally. It is no longer accurate to speak of one medical profession; rather there are many (see below).
(d) The fourth aspect of influence of the medical profession(s) is in its/their relationship to the management of the services and to those lay elements within management (ie lay in the sense of not containing a medical component; for example, administration and finance).

There are two main ways in which doctors (and some other groups of employees, like nurses) may participate in the management structure of the NHS. One is as individuals interacting with the governing body so as to affect policy-formation by individual advice, persuasion and pressure (medical administrators function in this way, as do Community Medicine Specialists). The other is through the formation of groups, which agree common views and policies and then (again by advice and persuasion and pressure) try to influence policy-formation with elected representatives acting as their spokesmen.

This second channel is of prime importance in medical organisation. One result of the reorganisation of the NHS has been a plethora of advisory committees at each level of the management hierarchy (in some health boards they exist only at area level). In a series of official reports (the 'Cogwheel' series in England; the Brotherston report(63) in Scotland; two reports published by the SHHD(64) on doctors in an
integrated NHS) the medical profession has been exhorted to participate fully in the management of the NHS. However, while the medical profession may possess the potential to exert considerable influence over matters such as resource-allocation decisions, there are constraints operating to counteract this. These are important since they relate to the crucial matter of 'medical dominance' in priority-setting.

There are three clearly identifiable constraints. Some documentation on these constraints exists, but confirmation of their importance was also provided by the field work carried out for this research. First, the medical profession itself is a constraint. It is no longer as homogeneous as it was several decades ago before the upsurge of medicine and medical technology. Developments in medicine, amounting to a scientific revolution in health, have resulted in the emergence of many new specialties, including neuro-surgery, heart surgery, psychiatry and so on. Such a proliferation has had the effect of weakening the unity of the profession as a whole which may lead to fragmentation, divergences of opinion between different specialties being a clear possibility. Other divisions are apparent too, between consultants and junior doctors, and between hospital doctors and general practitioners. Bevan capitalised on some of these intra-professional rivalries in order to establish the NHS in 1948.

Second, doctors are becoming more and more dependent on
the services provided by a host of paramedical occupations, like nurses (who, although a 'cut above' the rest in the NHS hierarchy, have not quite attained professional status), laboratory technicians, radiographers, physiotherapists, dieticians, etc. These groups act as constraints on the medical profession's hegemony because although in the past they were subservient to doctors, the latter now have to consider the views of these groups and accommodate them. Armstrong notes a gradual decline in strength of the medical hegemony over the last 25 years and argues that an increasing division of medical labour represents a challenge to medical dominance. Disputes in recent years in the NHS over pay and private practice have involved many of these paramedical and ancillary groups and have served to illustrate the interrelatedness of modern health care and the indispensability of the skills they provide. The reorganised NHS has provided the paramedical professions with channels of influence denied them before 1974. Their influence on decision-making may be expected to grow.

Finally, a third constraint is constituted by the failure of the medical profession to become properly involved in the management of the NHS. There is some evidence (admittedly rather scanty) to suggest that doctors regard committee work as a chore and many, if not most of them, try to avoid it or are ill-prepared for it. Reorganisation has increased the management tasks of clinicians; many, or most, are on some kind of committee. In evidence
to the Royal Commission on the NHS, a team of management consultants from McKinsey and Company\(^{(69)}\) suggest that 'the consultative machinery is too cumbersome and represents over-insurance by the professions involved'. The authors argue that unnecessary consultation is time consuming. 'In some areas, as many as one doctor in three is a member of some committee or team, taking up substantial amounts of his time!'\(^{(70)}\) There is, however, an ambivalence in attitudes expressed by doctors. They want to be involved in management and yet do not want to sacrifice valuable clinical time to the successful performance of a management role. In the longer term, they do not wish to compromise their clinical independence by assuming management functions. Since it is through such functions that they exert political influence this goes by default. Apart from this ambivalence, and the existence of genuine time constraints and role conflict, it has been argued that clinicians, by virtue of their medical ideology, find extreme difficulty in functioning effectively as a corporate group\(^{(71)}\) Reference has already been made to the concept of clinical autonomy and the ideological orientation of clinicians towards 'individualism'. Medical values militate against the formation of true collective action. This would suggest, therefore, that whereas individually doctors have (or had) power, collectively they risk losing it. Prior to Cogwheel (ie the divisional system) and reorganisation, doctors wielded considerable influence as individuals. Since Cogwheel
and the events of 1974, doctors have been expected to operate collectively as members of teams and groups and to reach a consensus on the issues before them. In short, doctors are now asked to give up individual power in order to achieve a collective say. It is not going to be easy for them to do this and the end result of these changes may be a diminution of the medical profession's influence as a corporate whole, although within the profession certain specialties may fare better than others. Much of the grumbling coming from certain parts of the medical profession over how 'disastrous' reorganisation has been suggests that these tensions may already be surfacing.

The medical profession is by no means the only important group in the NHS, despite the fact that its influence does permeate (whether negatively or positively) the entire decision-making process. The relationship between a health board and its officers is one of vital importance, yet very little is known about it. For example, what exactly does a health board do? What is its purpose? Is it necessary? Is it any more than a 'rubber-stamping' agency for decisions already effectively taken by the officers?

Relationships among the officers themselves at area and district levels are also worthy of investigation in order to discover the sources of officers' influence in the decision-making process and the ways in which they operate. For example, is the role of the Secretary a coordinating one, holding the organisation together by mediating
between the various factions, or does he possess his own 'sphere of influence' which he attempts to protect? If he has a coordinating role, does this give him greater authority than that possessed by the other chief officers? And if he has a sphere of influence does his coordinating role endear him to favourites?

In the reorganised NHS, it is intended that the consumer voice will be heard through Local Health Councils (LHCs). Since these Councils were still in the process of being established when this research was being conducted, no attempt is made to describe their impact on decision-making with respect to the allocation of DF. However, it is possible to make some preliminary observations concerning their role. A major question arises over the ability of LHCs to obtain the necessary information - and to know how to use it in order to affect in meaningful ways decisions relating to priorities and the allocation of resources.

This section has been devoted to a brief exploration of some of the themes and complexities surrounding the NHS which any study of decision-making must take into account. It now remains to define the boundaries of the research project more narrowly and to set some parameters on the breadth and depth of the case study. Any research that is going to be worthwhile must be of manageable proportions.

The present research concentrates on a particular decisional unit, comprised of those individuals responsible
for making a decision in a particular setting (in this case the process of allocating DF as conducted by two health boards). The main actors in the decisional unit can be grouped into three categories which collectively form a policy triad (it is not intended to imply that relationships within the triad are necessarily harmonious):

(a) Health Board, ie governing body: chairman and members;

(b) Officers: area, district and sector;

(c) Advisory Groups: professional and consumer.

These two concepts, the decisional unit and policy triad, together provide a means of focusing on the aspects of decision-making with which the case study is most closely concerned.

Two sets of findings emerged from the case study, which correspond closely to the study aims outlined earlier:

(1) The allocation process and DF. The case study set out to understand more fully than hitherto the mechanics of development fund allocations and the involvement of the policy triad in these. The study revealed, first, a number of constraints on decision-makers, such as time and the availability, and/or use, of information, and, secondly, some of the tactics and coping strategies which were deployed to circumvent or manage these, and other, anomalies (see Diagram 1).
NOTE: Policy Triad comprises 3 groups of participants involved in Development Fund allocations:

1. Health Board Members (governing body)
2. Officers: area and district levels
3. Advisory Committees: Professions and Consumers
New management structure. The case study investigated the specific organisational system activated by the development fund allocation process within the two health boards. In this exercise, the following relationships between the various participants were important:

(i) SHHD and health board;
(ii) Health board and officers;
(iii) Area officers and district officers
(iv) Officers and health care professions/consumers.

The kinds of issue raised in (1) above are important, and they are even more in the light of the reduced growth rate imposed on the NHS in recent years which has been accompanied by structural changes, introduced along with reorganisation, aimed at achieving a more efficient allocation of resources. The case study looked at this 'engineering' approach to resource-allocation and at the ways in which the process might be made more 'rational' and 'objective', as well as at the obstacles to be overcome, if, indeed, they ever can be overcome. The discussion proceeded from the perspective of the decision-makers' themselves, ie how they defined their environment.

In regard to (2) above, the research focused on (i), (ii) and (iii) since these, particularly (ii) and (iii), ie the relationships between health boards and officers, and between officers at different levels, are areas about which
very little is known. The relationship between the medical profession and administrators, (iv) above, has received more attention in the literature. It features in the case study insofar as it intruded into resource-allocation decisions.

1.4 Plan of Thesis

Part 1 provides a background for the case study by looking at the institutional arrangements of the NHS in Scotland since 1948. The greater part of this section concentrates on the events surrounding the reorganisation of the NHS in 1974. Chapter 2 describes the distinctiveness of the NHS in Scotland and the chief differences between its administrative structure and that of the English Service. It also refers to the managerial ideology which infused reorganisation, and attempts to analyse its attractiveness to policy-makers. Chapter 3 describes the principal features of the reorganised Service in Scotland, concentrating on the new management arrangements at health board level.

Part 2 is concerned with the theoretical and methodological foundations of the case study. Chapter 4 comprises a review of the literature on theories/models of decision-making and there is an examination of the controversies surrounding rational theories of decision-making on the one hand, and incrementalist theories on the other. These theories are reviewed not from the point of view of their normative and prescriptive applications but rather from
the point of view of their potential usefulness in helping to elucidate the allocation process described in the case study from the standpoint of the participants in that process. A framework derived from decision-making theory within which a decision process may be observed is outlined. In Chapters 5 and 6 the methodology adopted for the research is examined. In Chapter 5 the advantages and shortcomings of the case study approach in research are reviewed and reasons are given for its adoption in preference to other possible approaches. In Chapter 6 there is a description of the data-gathering techniques used, namely, observation, interviews, and documentary analysis. In addition, a questionnaire (reproduced at Appendix IV) was devised and circulated to the remaining thirteen health boards towards the end of the research project in order to ascertain whether the detailed observations obtained from the two health boards directly involved in the study were typical or atypical of similar processes in other boards.

Part 3 comprises the case study and is the empirical core of the research. Chapters 7, 8 and 9 contain descriptions of the roles of the three groups of decision actors which form the policy triad. The descriptions are more than just 'organisation chart' profiles. They attempt to relate some of the satisfactions, problems and anxieties experienced by the groups of participants so that these can be linked with the brief synopsis of the management structure provided in Chapter 3. Chapter 10 looks
briefly at the mechanics of the budgetary system as it affects the allocation of development funds. Chapters 11 and 12 focus on the determination of policy through development fund allocations over a two year period. They show the interrelationships and manoeuvrings between groups within the policy triad. The chapters illustrate some of the themes developed in Chapters 7 to 10. Chapter 13 contains an analysis of the development fund allocation process and finally, Chapter 14 draws some conclusions in regard to what has been learned from the case study about the activities of health boards, about decision-making and planning in such an environment, and about the relevance of decision-making theory in contributing to a better understanding of how the decisions described in the case study emerged. Even if broad generalisations are not realistically possible, drawn as they would have to be from only one case study, it is hoped that the research will provide some valuable insights into the running of the NHS at the health board level. If it contributes to a deeper understanding of that process, its purpose will have been more than adequately served.
PART 1

THE NATIONAL HEALTH SERVICE: Background to Case Study
Chapter 2
THE NATIONAL HEALTH SERVICE IN SCOTLAND

To appreciate the significance of the proposals incorporated in the reorganisation of the NHS in Scotland (from which the present structure is derived), it is necessary to sketch the administrative development of the Service since its inauguration in July 1948. This will also serve to indicate the differences within the NHS structure in Scotland which set it apart from the structures in England and Wales, and in Northern Ireland.

The NHS in Scotland stands as an independently constituted Service, although much of its general plan is identical with that of the Service in England. It was established for the same needs and aims, and it is associated with a body of social legislation common to the United Kingdom. The primary aim of the NHS is to make health care available to the whole population without financial barriers at time of need. There are also certain matters, especially in the spheres of financial provision and parliamentary control, and in the regulation of professional conditions of service in which the two Services must act in common. Some of these arrangements may be altered if devolution becomes a reality and Assemblies are constituted in Edinburgh and Cardiff.

However, the Scottish Health Service is not a mere variant on the Service in England. It has its own Act which contains substantial differences from the one establishing the
English Health Service. These differences arise from geographical factors and a separate local government structure. The two most important characteristics influencing the design of the Scottish Health Service are: (1) the size of the country (population: 5.3 million), and (2) the population in Scotland is less urbanised than it is in England.

Kellas\(^1\) in his book on the Scottish political system, lists the reasons for giving responsibility for the NHS to the Scottish Office in 1948. Apart from anything else, the decision was related to the existing tradition of health administration in the Department of Health for Scotland. Other reasons included the distinct local government structure from which many health services were inherited, the greater predominance of the teaching hospitals in the hospital system, and the problems of sparsely populated areas (ie principally the Highlands and Islands). Collectively, these special circumstances prevailing in Scotland necessitated modified arrangements.

The same factors were as instrumental in shaping the reorganised Scottish Health Service in April 1974, as they were in the creation of the Service.

The NHS in Scotland is administered by the SHHD under the authority of the Secretary of State for Scotland, who is directly accountable to Parliament for the running of the Scottish Health Service. The Service in Scotland was established by a separate Act (the NHS (Scotland) Act 1947), which has now been replaced by the NHS (Scotland)
Act 1972. The SHHD publishes a separate Annual Report on the health services in Scotland which is presented to Parliament each summer. The Scottish NHS has its own Hospital Advisory Service. Its role and objectives have remained unchanged since it was set up in 1970 at about the same time as its English counterpart, whose role has subsequently changed. The Service represents a Departmental field-presence through its hospital visitation programme and focus on facilities for mentally ill, mentally handicapped, geriatric and young chronic sick patients. There is also a Health Service Commissioner for Scotland, at present Sir Idwal Pugh, who is also Health Commissioner for England and Wales. The health 'ombudsman' has only been in existence in Scotland since shortly before reorganisation. The NHS (Scotland) Act provided for an ombudsman, and he took up his Scottish responsibility in October 1973.

Prior to 1974, the Scottish Health Service shared the tripartite division of functions with the English Service. However, the compact size of the country, both geographically and in population terms, has enabled Scotland to avoid many of the structural difficulties involved in setting up and administering the NHS, such as the scale of operations, the optimum size of administering authorities, and the establishment of good communications between the various tiers. The twin factors of geographical size and a manageable population have facilitated the formation of good working relationships between administrators at all
levels. They enjoy personal contacts with each other and with other professional groups operating within the NHS to a greater extent than is possible south of the border. Some evidence for this view may be found in the relationship between the centre (SHHD) and the health authorities on the periphery. There is the potential in Scotland for contact between these levels of administration to be close and easy to initiate or more so, at any rate, than is possible in England between the DHSS and RHAs. A report by RHA Chairmen who were invited to investigate the operation of the DHSS is critical of the relationship between the RHAs and the Department. The report expresses concern at the increasing centralisation of health service policy-making within the DHSS as against the delegation of much of this activity to the field authorities. It is not being suggested here that relationships in Scotland are devoid of friction. However favourable physical conditions may be in enabling easy access and good communication, obstacles of a political, economic or psychological nature can be encountered from time to time. The case study in Part 3 sheds light on some of these.

It has already been noted that the NHS is a British undertaking because the principles underlying it are uniform throughout the country. Yet, as has also been observed, there are marked divergencies when it comes to the organisation and structure of the Service in Scotland. These are not the only differences, however, and others ought to be mentioned since they all help to shape the decision-
making environment. For example, it is significant, but not widely known, that the NHS in Scotland is healthier in resource terms than its English counterpart. If England and Wales were to have funds which would produce per capita expenditure on the NHS equal with Scotland, then an increase of at least 15-16% would be needed. That means additional total expenditure of the order of £400 million a year at present values. As a direct result of this resource advantage, Scotland is better off than England in terms of the ratio of GPs to patients, and of staffed hospital beds and health expenditure to the population. Kellas\textsuperscript{4} wryly points out that some of these gains can be accredited to the Scottish Office 'for successfully maintaining the differential'. Sir George Godber (Chief Medical Officer, DHSS until 1973) firmly believes that this is the reason for the imbalance between Scotland and England. The most successful regional canvassing for extra funds has been by the Scots. 'That suggests that only separate ministerial advocacy for extra funds from the Exchequer is likely to be effective when the sums involved are so large.'\textsuperscript{5} Godber maintains that the SHHD with a smaller task and a relatively larger staff, as well as its own political regional advocate (the Secretary of State for Scotland), has always been in a position to exploit whatever opportunity there was within the central financing arrangements. Oral evidence to the Kilbrandon Commission by officials at the Scottish Office indicated that these special arrangements (ie separate
administration and separate political representation in the person of the Secretary of State who is a member of the Cabinet) might well have given Scotland a special advantage in Whitehall and Westminster when questions of resource allocation were being decided.\(^{(6)}\) Godber believes that the separate political voice of Scotland has resulted in extra resources being allocated to it, even though the case is just as strong for a number of English regions, in particular the three Northern regions - Yorkshire and Humberside, North West, and Northern region.

The other chief difference between the NHS in Scotland and the NHS in England lies in the medical sphere. It is important to understand that the Scottish medical world has its own distinctive history and institutions. The teaching of medicine has been an outstanding tradition for centuries, and the four university medical schools (Edinburgh, Glasgow, Aberdeen and Dundee) produce one fifth of all medical graduates in the United Kingdom. Not surprisingly, teaching hospitals are more numerous than in England. Kellas maintains that the position of the teaching hospitals was one of the strongest reasons for a separate administration for the NHS in Scotland.\(^{(7)}\)

The medical profession in Scotland deals with Scottish government agencies, especially the SHHD and the fifteen Scottish Health Boards [prior to 1974, it had to deal both with Regional Hospital Boards (RHBs) and Boards of Management (BoMs)]. Scottish doctors rarely have contact with the DHSS, except when general conditions of service or
salary scales are being negotiated between the Department and the British Medical Association (BMA). Moreover, the medical profession in Scotland has its own professional bodies, which have grown up independently of those in England, and which have achieved notable prominence. The Royal Colleges of Physicians and Surgeons (both in Edinburgh) and the Royal College of Physicians and Surgeons (Glasgow) are the oldest; the Scottish Radiological Society, the Scottish Committee for Community Medicine and Scottish members of the Royal Colleges of General Practitioners, Obstetricians and Gynaecologists and Pathologists, the Faculties of Anaesthetists and of Community Medicine join them in being recognised professional groups contributing advice through the National Medical Consultative Committee to the Scottish Health Service Planning Council (created in 1974 when the NHS was reorganised).

The BMA is also active in Scotland and its Scottish General Medical Services Committee contributes to the National Medical Consultative Committee. The Scottish Junior Staffs Group Council is a similar body to the Hospital Junior Staffs Group Council for England and Wales. Hospital consultants are represented through the Scottish Committee for Hospital Medical Services.

There is also a medical input at Departmental level. Within the SHHD, and assisting the Secretary of State with the central administration of the Scottish NHS, are a number of officers of the health professions. In addition to the Chief Medical Officer for Scotland and his staff of Medical
Officers, there is the Chief Dental Officer, the Chief Pharmacist, and the Chief Nursing Officers, all with their respective staff. Together with senior officials, the chief officers form the 'policy group', of which the Chief Scientist is also a member. Finally, there is the Chief Scientist Organisation within the SHHD. This is responsible for advice to the Secretary of State on research activities within the Scottish NHS.

From this brief review it is clear that the differences between the NHS in England and Scotland lie essentially in the area of administration and institutional arrangements. As subsequent sections attempt to show, differences in policy, where they occur, have been more subtle.

2.1 The Scottish NHS: 1948-1974

The machinery which emerged in 1948 after a series of protracted, and at times bitter, negotiations was the result of a number of compromises which Bevan (Minister of Health, 1945-51) was obliged to make if the Service was to avoid being stillborn. Politicians and others, including many doctors, were of the opinion that a move towards the unification and rationalisation of the delivery of health care was desirable, if not essential. But, as Ryan argues, the dictates of efficiency and economy were not the only factors to be taken into account when planning reform. A number of powerful interest-groups held strong opinions on the subject and they could not be ignored. The most influential of these were the BMA and the specialists in the Royal Colleges. Doctors were (and still are,
if one examines the underlying causes behind the pay beds controversy) extremely sensitive over the issue of State intervention in the running of the health services, and many saw such a development as the 'thin end of the wedge' which would ultimately erode their clinical freedom. Above all, doctors did not wish to become mere servants of the state.

There is no need here to trace the genesis of the NHS. This ground has been extensively covered in the literature. Suffice it to say that what finally appeared on the public administration landscape was a tripartite administrative structure which, although an advance on the previous haphazard and fragmented pattern, was no 'planner's dream'. Bevan could not risk upsetting the medical profession to the point where they might boycott the Service. Although imperfect from a rational administrative and planning perspective (the cumbersome tripartite structure and the unavoidable retention of private practice within the framework of a national health service were typical imperfections), Bevan's main objective, namely, to bring into effective operation a service that was comprehensive in scope and universal in coverage, was achieved. Godber is convinced that the administrative system set up by the 1946 Act 'was as far as we could reasonably expect to go at the time and a good deal further than a lot of people thought practicable'. He continues, 'the changes of April 1974 are equally about as far as we can expect to go at the present time and clearly have their
own imperfections'. The development of the Health Service, he asserts, 'is an evolutionary process which proceeds in a discontinuous manner' (12).

The Secretary of State for Scotland was responsible in different ways for each of the three parts of the NHS (see Diagram 2). Over 150 separate authorities were responsible for providing different aspects of health care. Under the NHS (Scotland) Act 1947, the Secretary of State was directly responsible for the provision of the hospital and specialist services. The 5 Regional Hospital Boards (RHBs) consisted of individuals appointed by him after consultation with a variety of bodies over a wide range of public and professional interests. Below the RHBs, 65 Boards of Management (BoMs) were responsible for day-to-day management of the hospitals. General practitioners were administered by 25 Executive Councils in order to retain their independent status vis-à-vis the State. Council members were appointed partly by local health authorities, partly by the professions and partly by the Secretary of State. The third arm of the NHS comprised 56 Local Health Authorities which provided a range of after-care community services in addition to preventive services. The Secretary of State had less influence over these authorities than he had over the other two arms of the Service. However, he could exercise control indirectly through Scottish Office relations with local government over the rate support grant and other matters.
DIAGRAM 2  NATIONAL HEALTH SERVICE (SCOTLAND) 1948-1974

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH HOME & HEALTH DEPARTMENT

SCOTTISH HEALTH SERVICES COUNCIL

HOSPITAL SERVICES

GENERAL PRACTITIONER SERVICES

LOCAL AUTHORITY SERVICES

REGIONAL HOSPITAL BOARDS (5)

EXECUTIVE COUNCILS AIDED BY PROFESSIONAL COMMITTEES (25)

COUNTY & BURGH COUNCILS (55 HEALTH COMMITTEES)

BOARDS OF MANAGEMENT (78)

GENERAL MEDICAL PRACTITIONERS

DENTISTS

PHARMACISTS

OPTICIANS

MATURENITY & CHILD WELFARE

HOME NURSING

HEALTH VISITING

PUBLIC HEALTH SERVICES.

CONSULTANTS

HEALTH CENTRES
Concessions were evident in all three parts of the structure. Because doctors disliked the idea of hospitals coming under local government control (for reasons to be explained later), voluntary and local authority hospitals were transferred to the Crown and organised under ad hoc regional and local agencies. Executive Councils were created as devices which would allow GPs to maintain their independence. GPs were (and still are) extremely hostile to the concept of a full-time salaried service. This hostility reveals itself in the reluctance of many GPs to give up their own practices in order to enter health centres. Local Health Authorities were necessary in order to placate feelings in local government. There was deep resentment in 1948 at the loss of control over hospitals. The government could not deprive local government of all its health services in one move (this had to wait until 1974, although no one suspected it in 1948).

In the circumstances then obtaining, no better balance was possible between the need for rationalisation and the requirements and/or objections of doctors. The structure survived 25 years which suggests that it was workable if not wholly rational. Grave doubts are currently being expressed as to whether the newly reorganised NHS will survive that long, or whether further 'tinkering' will be deemed necessary before then.\(13\)

The major division of the tripartite structure, in terms of size and resource consumption, was the hospital service.
Five RHBs were constituted to administer this service as agents of the Secretary of State for Scotland. The Chairman and members of each Board were appointed by the Secretary of State after consultation with interested organisations. Membership fluctuated between Boards. The largest in the West had 24 members and three of the Boards had 15 members.

The activities of RHBs can be grouped under four headings:

(i) Planning  (iii) Advice and guidance
(ii) Administration and Supervision  (iv) Direct services (eg Blood Transfusion Service)

The planning functions referred to capital works and expenditure and also to the appointment of all senior medical staff. Most RHBs operated through a series of standing committees and sub-committees. Since the amount of time which voluntary members could give to board business was limited, the major part of the work had to be done by permanent officers. The principal officers of the RHBs were the Secretary and the Senior Administrative Medical Officer (SAMO). Other senior officers included the Treasurer. RHBs were also required to appoint BoMs which would manage day to day functions of hospitals or groups of hospitals. BoMs were agents of RHBs but the relationship between them was a collateral one rather than a superior-subordinate one, as a previous BoM Secretary and Treasurer has noted. This relationship no longer applies in the reorganised structure.

One of the most interesting features of the BoM structure
was the joint post of Secretary and Treasurer. This practice was not duplicated in England and it has not survived the reorganisation of the Scottish NHS. The change has given rise to problems of coordination and cooperation between departments of administration and finance. The case study explores some of these difficulties.

2.2 Pressures for Reform
Reorganisation was under discussion for ten years or so before it finally occurred. Throughout the early and mid-1960s there were expressions of discontent with the tripartite structure. In particular, there was serious questioning of its effectiveness. Cooperation and coordination were not facilitated by an organisational structure divided into three separate sectors. For example, a patient at home in the care of his family doctor (under contract with the Executive Council) might have needed nursing care by a district nurse (employed by a local authority), and the GP might have wished specialist advice to be given by a consultant (employed by a RHB). Changing patterns of treatment merely aggravated these 'frontier' problems. For example, as Levitt(17) points out, the Mental Health Act, 1959 'radically altered the legislation on mental illness, reducing the grounds for compulsory admission and detention in mental hospitals'. Consequently, more patients were discharged back into the community and the emphasis in health planning was on the
need to plan hospital and community health services jointly. Integration of the administrative structure was felt to be necessary for a more comprehensive and efficient approach to health care. 'The tripartite structure impeded effective planning and coordination of services and contributed to serious imbalances in priority setting and resource allocation'.

Criticisms of the administrative structure did not come from the public, either as consumers or patients, but from within the Service itself, from among politicians, civil servants, hospital administrators, and professionals operating the Service. According to Draper et al as far as consumers and the majority of providers were concerned, prior to the reorganisation in 1974, 'it is clear that no obvious and widespread dissatisfaction existed'. The authors argue that the views of the consumers and providers of NHS services 'appear to reflect a positive acceptance of the NHS and a feeling that although efforts should be made to improve it, there could be no question of dismantling or radically altering it'.

The authors' arguments certainly apply to the public, but many of those concerned with the provision of services desired some form of reorganisation for various reasons (which will become apparent later).

Three reports were instrumental in leading to a government review of the NHS in Scotland. In 1962 the Porritt Committee, appointed by various medical interests to review the workings of the NHS, appealed for the integration
of the NHS. The Committee recommended the setting up of Area Health Boards supported by strong professional advisory machinery. Many of these suggestions, in addition to the principle of integration, found their way, in some form or another, into the final reorganisation. The Porritt report\(^{(21)}\) did not lead directly to any initiatives aimed at reforming the NHS but it helped to alter the climate of opinion as to the future shape of the NHS.

In Scotland, the Farquharson-Lang report\(^{(22)}\) argued a strong case for reform. The report was concerned with improving the administrative practice of hospital boards in Scotland, and much of the managerial philosophy and quest for greater efficiency and effectiveness which emerged quite forcefully as the central themes in the reorganised NHS (particularly in England) can be found in this report. Farquharson-Lang called for increased standards of management ability from officers and a clearer distinction between their functions and those of board members. The report also advocated a streamlining of the committee structure at BoM level, and proposed abandoning the 'house' committee system (ie where the business was subdivided on the basis of hospital units) on the grounds that 'they (ie house committees) encourage members to intervene in decisions of day-to-day management which we consider should be left to officers'\(^{(23)}\). Undoubtedly the report's most controversial recommendation was for the establishment of a chief executive post at each type of board (ie RHB and BoM). The post would be
filled either by a lay or medically qualified administrator, but the determining factor in his selection should be his ability and experience as a manager, not his professional qualifications. The entire report can be summed up in the following sentence: 'We consider that the stage has now been reached when the service must give greater attention to administrative practice and to the practice of management.' Although a specific examination of the tripartite structure was outwith the committee's terms of reference, the report surmised that before long 'the problem of integration between the three main parts of the NHS will need review, not only in relation to administrative practice, but also to the wider implications of the efficiency of the Service as a whole.'

A further appeal for integration came in 1967 with the publication in Scotland of the Brotherston report (the Scottish equivalent of 'Cogwheel' in England) on the organisation of medical work in the hospital service. The Committee made its position on the administration of the NHS clear in the third paragraph of the report's introduction when it noted that

> in the course of our discussions (we have) frequently been impressed by the fact that the present tripartite structure of the NHS militates against the provision of a properly coordinated medical service and creates problems which need not otherwise exist. We should, therefore, like at the outset to draw attention to the need for integration of the Service.

The report itself was concerned with the doctor's role in management and the need to improve relationships between
clinicians and administrators. Greater coordination between specialties was essential in order to realise this aim.

Further support for integration came in a book by Dr David Owen, MP (Minister of State for Health under Barbara Castle, 1974-76). But the three reports were in large part responsible for preparing the ground for consultations between the SHHD and administrative bodies and professional organisations on the future administrative structure of the NHS.

What is significant about the Farquharson-Lang and Brotherston reports is not simply their stress on the desirability of integrating the three divisions of the NHS, but their emphasis on improving management practices in order to make the NHS more efficient and more effective.

It is interesting to note that the final proposals for reorganisation were infused with a similar managerial style to that found in these two reports, particularly Farquharson-Lang. The two Green Papers published by the Labour government in 1968 and 1970 did not emphasise management to the extent that Sir Keith Joseph (Secretary of State for Social Services, 1970-74) did, but in his Consultative Document, circulated to interested parties only, in 1971, he went beyond Farquharson-Lang and gave management pride of place.

It is worth digressing at this point to draw attention to the reasons for this managerial approach to reform and to point out that interest in better management which would
lead to 'better', more 'rational' decision-making was not confined to the NHS. An essentially 'managerial' ideology of reform permeated public administration as a whole throughout the 1960s and early 1970s. This ideology will repay consideration since the present NHS structure is largely based on management criteria. Perhaps these developments have gone further in the English model but Farquharson-Lang and Brotherston have not been forgotten and the Scottish model has its share of management thinking.

The years of reform began in 1961 with the Plowden report which advocated the employment by government of the analytical techniques used in industry. In 1968 the Fulton Committee went further in recommending the adoption of management practices in the Civil Service. Together, these two reports performed what some regarded as the dubious service of looking at public administration as management in a political dimension and of paving the way for experimentation with new techniques such as accountable management, MBO and PPBS. In 1970 the Conservative government introduced a further application of 'business-like' methods in its White Paper on the reorganisation of central government. This resulted in the creation of 'giant' departments, like the DHSS, and the introduction of the PAR system. The White Paper emphasised the need 'to improve the quality of policy formulation and decision-taking in government' by defining 'strategic objectives' at all levels and by 'well-defined options, costed where
possible'.

Local government did not escape from this managerial influence. Many of the ideas developed in the Farquharson-Lang report were applied with vigour to local government. All the reports (35) concerned with aspects of local government, emphasised the need for coordination as opposed to fragmented policy formulation and implementation. The Bains report and its Scottish counterpart, Paterson, both stressed the advantages to be obtained from a corporate approach to decision-making, and were anxious to streamline the committee system in local authorities and to clarify the roles and responsibilities of officers and members (36).

The Heath administration which took office in 1970 was strongly biased in favour of management and the improvement of government decision-making. The 1970 White Paper on the reorganisation of central government has already been mentioned. Heclo and Wildavsky (37) refer to this period as 'the New Rationalism', and the search for 'a better way'. According to the authors, by the end of the 1960s, few people were happy with the way the government machine was working. The Conservatives while in Opposition had expressed an interest in improving the central machinery, and management science seemed to offer a better way of managing government. Heath was eager for new ideas and placed an emphasis on efficiency and policy analysis. He, and others, believed that government, like big business, required modern management. Two firms of
business consultants were hired to advise the leadership and 18 businessmen were selected from firms like Shell and Marks & Spencer to introduce the new techniques to government departments.\(^{38}\) It was in such a context and in such an atmosphere that the final proposals for a reorganised NHS were developed.

It is not easy to explain why this new managerial style caught on in the way it so clearly did. Some clues may be found in the above paragraph. In the early 1970s, the Conservatives clearly looked upon management as a panacea for deep-rooted problems affecting the delivery of public services, whether run by central government, local government, or by ad hoc agencies. Perhaps politicians and, among others, civil servants were of the opinion that if you got your institutions right then the way ahead would be clear. Since many of our institutions were not successful in performing the functions placed upon them during the 1960s and early 1970s, 'management' was seen as the remedy. Johnson\(^{39}\) claims that government has to work in a messy and refractory environment and its priorities are usually extensively determined by that environment. One may be tempted to try and escape the horror of 'disjointed incrementalism and muddling-through, but one cannot do so for long'. In other words, although the vision of smooth, rational, omniscient decision-making conjured up by management consultants is not applicable to government activities, it is paradoxically, and for that very reason, a peculiarly attractive one to those
unfortunate enough to be struggling along in situations of extreme complexity. Management is looked upon as creating order out of chaos. Whether or not this objective is fulfilled is debatable. La Porte\textsuperscript{(40)} is sceptical because it seems apparent to him that a great many actions and policies intended to make a situation more manageable (e.g., NHS reorganisation, local government reorganisation, central government reorganisation), that is to reduce both the complicatedness and uncertainty of a particular problem area, in fact often work to increase the complexity of the institutions attempting to address the problem.

The case study takes up some of these points, since the complexity of the decision-making environment obviously bears directly on the decisions emerging from it.

Apart from a mystical belief in the benefits of management \textit{per se}, there were other reasons for a recurring emphasis on management in the NHS. There was certainly a feeling at ministerial level that more effective management would enable the centre (i.e., DHSS) to gain more control over the administration of the NHS and over the allocation of resources as between different services.

There is no doubt that Richard Crossman, Secretary of State for Social Services 1968-70, felt impotent in the face of powerful RHBs. His lack of control over what went on in the field concerned him greatly. Crossman\textsuperscript{(41)} compared his relationship to these 'semi-autonomous Boards' to 'the relations of a Persian satrap to a weak Persian Emperor'. He also referred to RHBs as 'self-perpetuating oligarchies'. Owen\textsuperscript{(43)} shares Crossman's views. 'The old RHBs
built themselves up into extremely independent and powerful bodies'. He argues that the 'answerability of Ministers to Parliament may have given the semblance of control, but on some major aspects of health care there has been little central direction or control'. 'Cinderella areas' like mental handicap and the long-stay hospitals have been 'seriously neglected', and central control 'has had less influence on the major national issues of priorities and financial allocations than one would reasonably expect. Parliament's control (operating through the DHSS) over the health service has, in fact, been surprisingly weak'. Owen does not elaborate on why this should be so, but he has long been a critic of Parliament's ineffectiveness in scrutinising the executive. The performance of Parliament on health matters is akin to its performance in other areas of activity. Health probably receives less attention, a fact which may reflect public attitudes generally. Unlike education, for example, which attracts considerable attention and is perceived to be at the centre of endless political machinations, health has retained an almost clinical detachment and is regarded as being in some way 'above' politics. Only when it comes to scandals in long-stay hospitals, or to outcries about the shortage of kidney machines, do MPs become activated. Battistella and Chester note that in practice, the powers of the Minister were also quite limited in the hospital service because of the weight of orthodox thinking and interlocking dependencies which favoured technologically intensive hospital-based
services for acute illness over the development of low-technology community-based primary services and the care, as distinct from cure, of the long-term chronically ill.

Klein suggests that

the point is sharply made by the outcome of the attempts made by successive Ministers over the past decade, irrespective of party, to shift more resources to the care of the old and chronically sick in hospital .... These attempts have only had limited success: the elderly and chronic sick .... still get far less in terms of resources .... than those in acute beds. The explanation is that central priorities are filtered through the local administrative machinery dominated by consultants belonging to the traditionally prestigious specialties.

Klein maintains that 'the new organisation (ie reorganised NHS) is designed to strengthen the centre's managerial control over the distribution of resources'; In a discussion of the planning system which is coming into operation in the English NHS, Watkin suggests that the planning system provides 'ample scope for the exercise of central control and political interference'. He believes that the planning system 'might be seen as an exercise designed on the one hand to make the reality of central control acceptable to the periphery, and on the other to provide a flow of information upwards to ensure that central policies and guidelines do not become out of touch'. Although this move towards more effective central control has gone farthest in England (which is perhaps natural considering the size of the Service south of the Border and the large amounts of resources it consumes), there has been a 'spillover' of the planning approach from the English Service to the Scottish one. However, the
Scottish planning process does not possess the centralising tendencies or the rigour of the English planning system.

If an interest in better management was in large part the result of the DHSS' desire to become more effectively involved in policy formulation and implementation, then it is necessary to explore the motives behind what was an increasingly directive posture. These motives may be found by examining the fundamental and seemingly intractable problems which face the NHS. Reorganisation was seen, not simply as a way of correcting the deficiencies which had appeared within the 1948 structure, but also as a way of coming to terms with a whole new series of underlying problems which posed such dilemmas to NHS policy-makers. The desire for (the uncharitable might say the obsession with) improved management (through which more effective central control could be established) was to a large extent symptomatic of a wider concern with the need to tackle, and possibly to resolve, these fundamental problems. It is possible, therefore, to make a distinction between the need for structural reform of the NHS, and the managerial style which actually infused the re-organisation proposals. It is quite conceivable, in other words, that structural reform could have taken a very different direction. For example, a participative style (using the term to mean democratic accountability) would undoubtedly have led to a different structure, with a much greater emphasis on lay participation.
The major problems facing the NHS stem from a complex mix of rising demand, rising costs, and rising expenditure on health. In the 1960s and early 1970s, these issues were quite separate from the immediate difficulties arising out of the shortcomings of the 1948 structure, which at most only served to exacerbate these fundamental problems. It is important to emphasise that what has been referred to as 'the growing dilemma' in health care is not peculiar to the NHS. All health care systems in modern industrial societies, however these systems are organised and financed, are facing similar problems. This dilemma can be summarised as follows: 'Paradoxically, with every broad advance in medicine and public health, the task of providing adequate health care has become formidable'.\(^{50}\)

The McKinsey survey noted that

> neither in Britain nor elsewhere in the survey countries (ie Western Europe, United States, and the Soviet Union - 20 countries in all) are there signs that health needs and health resources are approaching a natural balance ... . Everywhere the cost of health services continues, year by year, to outstrip the rate of national economic growth.

According to the report, everywhere

health needs and demands will continue to rise faster than the resources available to meet them. Needs will rise with the average age of the population; demands will increase, as a result of rising needs, medical advances, and higher expectations. \(^{51}\)

It has been estimated that the cost of the NHS in 1978 will be £8,000 million,\(^{52}\) as compared with £1739 million in 1968. The total cost of the Service in Scotland in 1974-75 was over £485 million, compared with over £333 million
in the previous year and £121 million fourteen years ago (ie 1964-65). Allowing for changes in the value of money, there has been a real increase in health service expenditure of about 60% during this ten year period. Two-thirds of all NHS expenditure is consumed by the hospital service (72% of total expenditure went to the hospital service in 1974-75 with community health services accounting for over 5% and GP services for over 16% of expenditure), and, since the NHS employs about 1 million people (113,000 in Scotland in 1975) it is hardly surprising that over 70% of all expenditure goes on salaries and wages. Health is a labour-intensive activity.

The roots of the problems outlined above go back, as far as the NHS is concerned, to Beveridge\(^{(53)}\) who, in 1942, laid down the philosophy from which the NHS emerged. Beveridge believed that there was a finite amount of ill-health, and that this could be eliminated by a policy of spending money on medical care. Once a backlog of neglect had been removed, he believed, the demand for services would stabilise. Health in Beveridge's view was a sound economic investment on the grounds that it would produce a healthy, productive work-force. But the anticipated levelling-off never occurred. To all intents and purposes, the NHS was founded on a fallacy. Health is now recognised as a form of consumption which is both insatiable and infinite.

For a time (after Guillebaud)\(^{(54)}\) it was thought that managerial efficiency and effectiveness, based on modern
efficiency techniques, would solve the problems but by the early 1960s it was becoming clear that Beveridge's hypothesis was not only inadequate, it was actually being turned on its head. The NHS was so successful that it was simply keeping people alive to be ill more often. It was creating ill-health by storing up future demands which would manifest themselves in an increasingly aged, dependent population. Incurable chronic diseases were taking the place of curable acute illnesses. The paradox of the whole situation is that the more successful the NHS is, the more expensive it becomes. In the acute areas more sophisticated diseases which are more costly to cure replace existing ones and the law of diminishing returns is all too apparent in this sector - ie high costs and incremental advances. This has led to imbalances in service provision. The problems of an aged population, it is widely believed, require solutions which emphasise the 'caring' function rather than the 'curing' function. The NHS before reorganisation was inadequately equipped to plan in this direction.

The benefits claimed to derive from high-technology medicine have been questioned by, among others, Powles, who argues persuasively that increasing expenditure on scientific medicine has resulted in diminishing returns. According to Powles, what is required is a

switch away from emphasising the potency and potentiality of high-technology clinical intervention towards an emphasis on the importance of way of life factors in disease ... . Resource shortages and other pressures are likely to push
medicine towards the alternative - 'ecological' - strategy for the further improvement of health. (56) Illich (57) argues along similar lines, although his tone is more shrill and uncompromising. In a characteristically argumentative pose, Illich's opening sentence reads, 'The medical establishment has become a major threat to health'. Relentlessly Illich produces evidence showing the impotence of medical services to change life expectancy, the insignificance of most contemporary clinical care in curing disease, and the increasing problem of iatrogenesis (ie doctor-made illness).

Although Powles and Illich, both writing in the 1970s, (58) have been forceful in their views on the limitations of modern medicine, during the 1960s there was a greater awareness that medicine alone had little to do with the reduction of mortality and morbidity, with greater longevity, and the maintenance of a high level of health status. It was accepted more and more that improvements in health resulted from improvements in nutrition, housing, sanitation, and a concern for a better quality of life.

Increasing expenditure on high-technology medicine might be justified if positive benefits resulted from such an investment. The difficulty arises in isolating these benefits. For example, the need for intensive coronary care units has been questioned, as has the preconceived idea that treatment in hospital must be better than treatment at home. (59) Teeling-Smith (60) has also expressed some concern over the benefits which are said to come from increasing technological advances in medicine.
A particularly worrying aspect of this matter relates to the increasing concentration of health care resources in the hospitals. It is from there that most of the evidence of wasteful and inefficient activity originates. In addition, it is the hospitals which have indulged in the most elaborate and expensive technology such as the latest X-ray diagnostic procedures (EMI-scanner) ....

Sections of the medical profession would disagree with much of the foregoing analysis. Their views may be summed up in the following passage from an editorial in the British Medical Journal: (61)

As medical technology continues to advance, the treatment of coronary thrombosis, stroke, lung, bowel, and breast cancers, .... , and the other really common illnesses in our society will continue to improve and become more expensive. Faced with a life-threatening illness, every citizen has a right to expect the NHS to provide him with the best treatment available, or, at the very least, treatment along the lines agreed to be most effective by orthodox medical opinion. .... The gap between performance and expectation is widening daily. In part, the answer lies in finding more money for the acute services (emphasis added).

The quotation captures the ideological principles on which most current medical practice is based. Chapter 1 noted how a doctor's role tended towards particularism rather than universalism and that great importance was attached to a doctor's individual responsibility. The emphasis placed on scientific medicine stems from a doctor's refusal to accept his inability actually to cure, rather than to alleviate, illness. The fact that patients, relatives and others expect doctors to prescribe wonder cures only reinforces a doctor's commitment to a medical model of health and disease. For a doctor to admit to being unable to cure a patient means, in effect, an admission of failure.
since his role is perceived as a curing one. This leads to a situation where technical procedures are often employed to convince doctor and patients that he is doing something and thus conceal the lack of knowledge and the lack of effective treatments. 'Many medical actions are magical placebos ...' but 'the underlying problem and ways of handling it remain as a result largely unconfonfronted - when financial constraints are reached then we all blame the DHSS or the Treasury for not devoting enough money to health care'. (62)

Therefore, perhaps the greatest dilemma of all is the fact that despite the medical emphasis on acute services, spending money on health care, particularly in the acute sector, has not had much impact on improving the nation's health. Ill-health has been reduced little if at all, and new diseases replace older ones. If progress has taken place, then it is more than likely that this can be traced to factors which lie outwith the NHS's jurisdiction. The state of health in Scotland lends weight to this line of argument. If spending money on health solved ill-health, then Scotland should be a healthier nation than England. As we noted earlier, more is spent per capita in Scotland on health than in England. Yet the Scottish population is not healthier. Far from it. For example, it has the second highest mortality rate in Europe from ischaemic heart disease; (63) and cancer, alcoholism and cigarette smoking are problems which are giving rise to mounting concern in Scotland.
Increasingly in the late 1960s and early 1970s it was realised that many of the more common forms of disability like heart disease, cancer (both major causes of mortality and morbidity) and mental-emotional disorders, are largely unpreventable and often incurable by medical methods. This trend culminated in the DHSS publication: Prevention and Health: everybody's business. The best hope for attacking many health problems lies not so much in improved surgical techniques and clinical interventions as in more mundane health education for altering behaviour and in social policy initiatives designed not to 'blame the victim', ie those which try to avoid blaming people for getting ill. 'The imperviousness of contemporary disease problems to acute treatment methods ... reduce the potential of technology at a point in time in which it is becoming increasingly more expensive ...'. As has been suggested, the Scotland/England resource imbalance operating in favour of the former supports this view. It can be convincingly argued, that Scotland requires more preventive measures, in the form of better housing and improved diets, rather than more ICCUs, EMI-scanners, and so on. The fact that heart disease is not impressively affected by medical intervention was admitted recently by the Royal College of Physicians in a report which blamed our national diet as a major cause of heart disease. The report emphasised that changes in life-style were necessary to prevent heart disease (and changes in life-style depend on changes in social policy). Doctors had only a limited
role to play.

Apart from developments in medical technology adding to demands for more resources, there are also other contributing factors which must be considered. Not only are costs rising with growing demands on the Service brought about by population increases, particularly in the older, more dependent age groups, but they are rising as a result of a 'revolution in expectations' which has occurred because of higher standards of living. People, according to this view, are no longer simply concerned with quantity but also with the quality of life. The same standards of comfort that people are accustomed to in their daily lives are also demanded in hospitals. These attitudinal changes have resulted in people experiencing a lower threshold to disease in society. Increased expectations add to the burdens upon the NHS, as do the constant discoveries in new technologies and new forms of treatment. If something is available, or can be done, then people want it. The survival instinct drives people to make all sorts of 'irrational' demands on the NHS, and this situation creates tension between what is technically possible and what the NHS resources can sustain.

The crux of the matter is that there is no provision of health care beyond which one can say that further expenditure is wasteful or undesirable. The concept of 'need', as Cooper, among others, has argued, is an elastic one. One person's need is often another person's demand. Need is a matter of judgement and opinion, and is not an
absolute state. In practice it is defined by the medical profession in terms of what treatments they are prepared to provide and to whom they are prepared to administer these.

It has been established that by the mid-1960s the government was becoming increasingly troubled by the cost, efficiency, and effectiveness of the NHS. The above discussion has illustrated the background to this concern. To some extent the whole concept of 'health' and what is meant by it was under review. What emerges from an analysis of these deeper issues is that for Britain's increasingly aged population and for people suffering from diseases which do not respond favourably to high-technology medicine perhaps the 'caring function' is more relevant than the 'curing function', with additional emphasis also being placed on preventive measures. Powles (68) claims that there is 'a growing recognition that the 'care' function of the health services is in direct competition for resources with the 'cure' function and that hitherto 'cure has had more than its fair share'. A switch in strategy away from high-technology hospital medicine to the non-technical, 'helping to cope' side of medicine is necessary. Caring (reducing imperfection) is more important and more realistic than curing (creating perfection).

Reorganisation of the NHS was in large part intended to assist in bringing about this strategic shift.(69) It must be pointed out that the government's motives were
perhaps not as humanitarian as might appear to be the case. The government was (and still is) primarily concerned about the problem of increasing costs. Emphasising the caring function was seen as a possible way of keeping overall costs down by expanding less costly community services while containing expensive hospital ones. This strategy would also enable existing resources to go further. Patients' interests were, as is often the case, entangled with other considerations of a political and economic nature.

For a complex variety of reasons, the principal ones having been considered in this chapter, reorganisation finally materialised. Although 'the growing dilemma' referred to is not amenable to solution merely by administrative change, there is little doubt, as the three reports discussed earlier illustrate, that the tripartite structure was a positive hindrance to any solution of this dilemma.

2.3 Conclusions
Reorganisation was deemed necessary for five reasons, all interrelated. The major obstacle posed by the tripartite structure was a lack or coordination and cooperation between the three separate parts of the NHS. This denied any continuity between hospital care and community care since these functions were organised under separate authorities. Some patients, to their detriment, fell between these somewhat arbitrary administrative boundaries.
Second, problems of coordination resulted in an inability to plan services effectively. Planning was piecemeal and no overall view of the Service was possible. Third, because costs were rising so steeply the need to use existing resources as effectively as possible was of paramount importance. The NHS could not continue to devour such a large proportion of the GNP. (70) A unified NHS, it was believed, could lead to a better use of resources by switching the emphasis from acute hospital services to community services and long-stay care. Fourth, there was a view held by administrators, and by some doctors, that local authorities were slack in providing adequate community services. Since such services were not vote-catchers, it was alleged, they did not receive the priority that they ought to have. Local authorities, of course, did not see things this way. Since they have to cope with many competing demands on their resources they are often unable to give priority to community services even if they wish to do so. Nevertheless, lack of coordination in service provision between the two sets of authorities resulted in patients being kept in hospital who ought not to have been there. Klein (71) has pointed out that many doctors in acute specialties favoured some form of reorganisation in the hope that their acute beds would cease to be clogged with patients who really ought to be treated in the community. Finally, politicians and civil servants saw reorganisation as an opportunity to challenge the exclusiveness of the medical profession in deciding
what, and how, services should be provided and to whom. Attempts by various governments prior to reorganisation to redirect resources from acute services to the most vulnerable sectors within the NHS were not completely successful. One has only to read through the annual reports of the Hospital Advisory Service in order to appreciate how little has changed and how much remains to be done.

As the momentum gathered pace on the question of NHS reform, reorganisation was seen as inevitable even by those who were not committed to any reform. However, among those who were interested in change, each faction had different reasons for wanting it, and each group hoped to gain from it in different ways. There may have been fairly widespread agreement on the need for reorganisation, but there was consensus neither on the precise form this should take nor on the objectives for which one might want to reform the structure. Hence, the reorganised NHS of 1974, although an improvement on the 1948 model in some important ways, is once again the result of compromises forged between competing interests, rather than the outcome of rational planning. It is a 'satisficing' solution.
In Chapter 1 the pressures for reforming the NHS were examined and an attempt was made to account for the managerial ideology underlying reorganisation. In this Chapter the structure to which this 'managerial style' has given rise is looked at in detail.

Reorganisation of the NHS in Scotland occurred at the same time as the reorganisation of the Health Service in England and Wales (ie 1st April 1974), although the Scottish Act was passed by Parliament one year before the English Act. Events moved more swiftly in Scotland, because only one Green Paper was published (as opposed to two in England). Moreover the Consultative Document issued in 1971 applied only to England, although the philosophy on which it was based found its way into the White Paper on the NHS in Scotland published in July 1971. This White Paper revealed the government's proposals for legislation to reorganise the NHS. The NHS (Scotland) Bill was introduced in Parliament in January 1972 and received the Royal Assent in August 1972. There remained just under two years for preparations to be made to implement the new arrangements before the appointed day.

In Scotland, no specific study was commissioned to formulate management arrangements for the new structure. But although the 'Grey Book'(1) did not apply to Scotland, the
SHHD issued a series of circulars (familiarly known as 'Blue Band' circulars) which gave guidance to the then existing health authorities on necessary preparations for the changeover in April 1974\(^2\). Much of the management theory contained in these circulars resembled that underlying the English management arrangements.

3.1 The Proposals

The Green Paper issued in 1968 by the Secretary of State for Scotland\(^3\) coincided with the first English Green Paper. True to the format and purpose of a Green Paper, the document was in no way a statement of government policy. The Secretary of State's repeated use of the word 'tentative' in his foreword (3 times on page 6) when referring to the proposals for change confirmed this. The Paper's main theme was that the tripartite structure should be replaced by a unified integrated Service, which would enable priorities to be better determined and carried out, and which would avoid any duplication of tasks. A single-tier structure to replace the panoply of boards, councils, and authorities was envisaged whereby a number of area boards would be in charge of planning and day-to-day management. The structure was to be more comprehensible than the division of functions between BoMs and RHBs.

Perhaps the most interesting feature of the Green Paper, apart from its rejection of any review of the personal social services which had already been reviewed and re-organised under the Social Work (Scotland) Act 1968,\(^4\) was
its suggestion that the reorganised NHS might come under local government control. This proposal was certainly favoured by Redcliffe-Maud who chaired the Royal Commission on local government in England. The Commission's report\(^{(5)}\) suggested that consideration should be given to the possibility of unifying responsibility for the NHS within the new system of local government. But the Green Paper did emphasise that 'there was no welcome for the suggestion that all health services should pass into local authority control!'\(^{(6)}\) The argument concerning the relationship of the NHS to local government began before 1948, when the Service was created.\(^{(7)}\) Those in favour of local government control of the NHS maintain that democratic control over the NHS would be more effectively secured if it was directly answerable to the electorate rather than to higher authorities. **Ad hoc** health authorities give rise to concern about the lack of accountability of the NHS to the public. Moreover, under local government control better opportunities might exist for establishing close relationships between the NHS and the personal social services since **ad hoc** health authorities require special arrangements in order to facilitate necessary cooperation.\(^{(8)}\) Finally, it is claimed that with the new regional tier in local government in Scotland which is supposed to allow for more efficient managerial units, there is no reason why the NHS could not be run by local government.

The case against local government control rests primarily on professional opposition to it.\(^{(9)}\) The medical profession
in particular believes that only a Service administered by special bodies, on which the profession is represented, can ensure clinical freedom. Local authority members are perceived as being parochial, obscurantist and ignorant of medical matters. Under local government control, there would be constant interference, and conflict would be inevitable between clinical interests and party political ones. There are other problems too. The danger exists that regional differences would emerge if local government controlled the NHS which could result in the appearance of different standards of care throughout the country. Some areas would become more attractive to work in than others (this is the case at present, but it would be exacerbated if such differences were allowed to occur as a matter of choice). The other problem concerns the financial resources necessary to run the NHS. The rating system in local government could not bear such a burden. If central government allocated funds then this would further antagonise the already uneasy relationship between central and local government.

The government, which changed in 1970 from a Labour to a Conservative administration, accepted these objections (a Labour administration would most probably have done likewise). In the Scottish White Paper, (10) there was no mention of the NHS coming under local government control. The structure proposed followed the broad lines set out in the Green Paper. A single-tier structure was envisaged comprising 14 health boards (this later became 15 health
boards with changes in local government reorganisation). The White Paper conveyed very little information in its 17 pages on the shape that the structure would finally take, leaving the precise management arrangements to be adopted by the health boards themselves who were required to submit schemes to the Secretary of State for approval. The White Paper emphasised the need for the establishment of a strong professional consultative structure which would enable professional occupations to contribute to the day-to-day management of the Service. This idea originated from a report published in 1971 by a SHHD working party. The White Paper also noted that 'the Government are anxious to encourage the interest of local people in the running of the health service' and referred to the original Green Paper's proposal to establish local committees which became local health councils in the White Paper.

For more detailed information on the precise form taken by the reorganised Scottish NHS, it is necessary to examine the Blue Band circulars. The series began in September 1972, and covered a whole range of matters from salary scales for officers, to descriptions of the management structure of the new health boards. Diagram 3 illustrates the principal features of the reorganised Service in Scotland. If one compares this diagram with one illustrating the English structure (Diagram 3a), it is possible to note some significant differences between the two models. Indeed, there are more differences between the two Services now than there were under the previous structure.
DIAGRAM 3a  NATIONAL HEALTH SERVICE REORGANISATION
ENGLAND 1974

SECRETARY OF STATE FOR SOCIAL SERVICES
OFFICERS OF THE DHSS

14 REGIONAL HEALTH AUTHORITIES

90 AREA HEALTH AUTHORITIES

FAMILY PRACTITIONER COMMITTEES

AREA OFFICERS

DISTRICT MANAGEMENT TEAMS

DISTRICT MEDICAL COMMITTEES

MANAGEMENT BELOW DISTRICTS: SECTORS/UNITS

200 COMMUNITY HEALTH COUNCILS

PROFESSIONAL ADVISORY COMMITTEES

REGIONAL OFFICERS

• • • • EXTERNAL RELATIONSHIPS

CORPORATE ACCOUNTABILITY

INDIVIDUAL OFFICER ACCOUNTABILITY AND
JOINT TEAM RESPONSIBILITY

MONITORING AND COORDINATING BETWEEN
TEAMS AND INDIVIDUAL COUNTERPART OFFICERS

REPRESENTATIVE SYSTEMS

EXTERNAL RELATIONSHIPS
For example, under the new arrangements, there is no regional tier in Scotland. Whereas lay members operate at two levels in England (Regions and Areas), they operate only at area level in Scotland. In Scotland, the health boards have more direct authority over their districts than the English AHAs have. In the Scottish arrangements there is a direct line management relationship between district officers and their area counterparts. This is not the case in England. 'The officers of the Area Team of Officers (ATO) will not be the managers of their District counterparts, nor will they be accountable for District performance, both sets of officers being directly accountable to the AHA'.

Integration between primary care services and the health service has, on paper at any rate, been more successful in Scotland than in England. Family Practitioner Committees (FPCs) have been established in England, replacing the former Executive Councils, which are independent of the AHAs although the authorities have overall responsibility for health care in their respective areas. There is scope for conflict here and problems have arisen. The difficulty is that 'the FPC is, like the AHA itself, a body corporate with perpetual succession and a common seal. Accordingly .... it is not a Committee of the AHA. The FPC is thus a distinct body from the AHA with prescribed functions of its own'. In the opinion of one administrator, 'the FPC is something more than a mere instrument of the AHA: its nature is more that of a
principal, possessing effective statutory powers and duties of its own.\(^{(15)}\) Problems arise because some AHAs argue that GP services are too isolated from the rest of the NHS.\(^{(16)}\) In Scotland, the Executive Council structure has been abandoned in favour of the administration of independent contractor services by health authority committees (i.e., General Medical Practitioner Committees). The potential, therefore, exists for a greater degree of integration in the Scottish NHS although in fact 'this in itself may not be any more satisfactory than the arrangements in England and Wales'.

The health care planning system in Scotland is very different from that devised for England, both institutionally and in terms of approach. In Scotland there is a Planning council (advised by seven National Consultative Committees) which has no English equivalent.\(^{(17)}\) Also, in England, the emphasis has been on comprehensive health planning with the development of an annual planning cycle in which the centre plays a key role. Indeed, perhaps the main distinguishing feature of the English Service is the increasingly directive role which the DHSS will play (or attempt to play) in the planning system. In Scotland, where the need for firm central control is probably less, because of the manageable size of the country and the Service, a greater emphasis has been placed on flexibility and participation and strategic, as opposed to comprehensive, planning.\(^{(18)}\)
3.2 The Structure

In this section the principal organisational features of the reorganised Scottish NHS are outlined. In the next section particular features of the new structure, knowledge of which is necessary as background for the case study, are analysed in more detail.

Ultimate responsibility for the administration of the health services in Scotland lies with the Secretary of State at the SHHD. Reorganisation has resulted in two particular innovations at national level. The Scottish Health Service Planning Council, representing all the health boards, as well as university and Scottish Office interests, exists to advise the Secretary of State on the exercise of his functions, whether at his request or on its own initiative. According to its Annual Report for 1974\(^{(19)}\) the Planning Council sees itself as an important part of the central administration of the NHS with a 'key part to play in opening up new possibilities in regard to the provision of health care in Scotland'.

Whereas the fragmented structure of the NHS prior to reorganisation inhibited the growth of any long-term strategy for health care, 'the primary task of the Planning Council ... is to advise on how such a strategy could be initiated and developed'\(^{(20)}\) The Council's deliberations will have three main aspects: identification of priorities; advice on how to implement agreed policies; and evaluation of the success of the policies. The main work of the Council to date has consisted of establishing Programme Planning Groups
focusing on specific client-groups like the elderly, the mentally disordered, children and so on (similar Planning Groups have been set up by some health boards).

The Council was also involved in approving the recommendations made in the SHHD memorandum reviewing health policies and priorities for the period up to 1979/80. The work of the Council is inevitably long-term in character. However, according to the Council's Annual Report for 1977, during that year 'substantial progress was made towards a stage in which it should begin to be possible to deal with problems of health care in Scotland in terms of those 'longer, broader and deeper' perspectives which lie at the heart of a planning approach'.

The other development at national level has been the creation of a Common Services Agency (CSA). Brown has suggested that the CSA provides an interesting example of the civil service doctrine of 'hiving off'. In addition to providing services that the health boards could not be expected to provide for themselves, such as the execution of major building projects, the Agency has taken over some of the functions previously carried out either by the SHHD or by the old RHBs, including the ambulance service, the blood transfusion service, research and intelligence, and health education. The CSA is part of the NHS, not of the civil service. It operates through a Management Committee appointed by the Secretary of State. This Committee consists of a chairman and five members appointed by the Secretary of State and six members appointed by him on the
nomination of health boards acting jointly. In addition, other members may be appointed after consultation with health boards.

The main operational agencies of the NHS are the fifteen health boards. These correspond to the new local government regional and island authorities, except that the Strathclyde region has been divided into four health board areas. Where appropriate (see below), areas have been divided into districts for management purposes. Five health board areas have not been divided into districts, and, of the remainder, one health board is divided into five districts, one into four districts, four into three districts, and four into two districts. There is also a management structure below the district level which usually takes the form of sectors based either on a large individual unit or groups of smaller units, comprising hospitals and clinics together with community services. As in the case of the areas, the principle of coterminosity has been enshrined and, where possible, district boundaries have been drawn to coincide with one or more of the local government districts.

In terms of population, there is considerable variation among the health boards. The largest board, Greater Glasgow, has a population of 1,205,000 million while the smallest, Orkney, has a mere 17,500. A cluster of boards comes within the population range 300,000 to 450,000. The disparities between the remaining boards are too great to group conveniently. Membership of health boards also
varies. Three boards have 22 members, five have 20 members, three have 18 members, and four have 14 members. In total there are 276 members, drawn from a wide range of interests (industry, finance, commerce, farming, trade unions, universities, local government, health care professions) and all appointed by the Secretary of State. The SHHD's annual report for 1974\(^{(24)}\) states that members were appointed for their potential contributions as individuals. In no sense do they represent the interests by which they were nominated or, in the case of staff employed by or in contract with the health service, their professions. Members are expected to participate fully and objectively in the work of the board and to share responsibility for all decisions of a management authority directly accountable to the Secretary of State.

However, since 1974, certain changes have occurred in the composition of health boards. These are the result of proposals set out in a discussion paper [The NHS and the Community in Scotland](#x28;25#) The document marked the Labour Government's promise to review the organisation of the NHS with particular reference to the system of management. 'The changes proposed are designed to make the system more responsive to the views of those it serves and to take greater account of the contribution which those who work in the service can make to its management'.\(^{(26)}\)

In his Consultative Document\(^{(27)}\) Sir Keith Joseph had pointed out that the new health authorities would have important and complex management functions to perform. These would demand of board members skill and expertise. Since 'management ability will be the main criterion for the selection of members', it would be inappropriate for authorities to be
composed on a representative basis. Management and representation must be separate in order to avoid confusion between management on the one hand and the community's reaction to management on the other.\(^{(28)}\)

Under the original arrangements for establishing health boards, members of the health care professions were eligible for membership of boards only if they were not in direct management relationship with the senior officers of those boards. This meant that membership was limited to doctors, dentists, pharmacists, opticians and people with nursing experience who were not employed by health boards. Under the new arrangements, which are being implemented as board members' terms of office expire, the Secretary of State feels

that the service should take full account of the experience of those who work in it and that all categories of staff in the health services should be eligible for membership, the only exception being that senior officers of area and district executive groups should not be appointed.\(^{(29)}\)

Apart from health care professions and staff working in the NHS, the Secretary of State also wants to increase the number of local authority nominees; to assign places on boards to representatives of the trade union movement; and to appoint people with a known and genuine interest in the health service. Other than widening the catchment area for potential health board members, the document did not propose to alter in any fundamental way the role of the board member as prescribed in the White Paper and elsewhere.

It is important that the role of members of health boards should be clearly understood.
Members are appointed for the contribution which they can make as individuals and, while they will be able to bring with them knowledge and experience from other spheres such as local government or service within health establishments, it must be clear that they in no sense represent the interests by which they were nominated. (30)

This is a radical departure from past practice. The function of representing the public's interest in health care is now vested in separate Local Health Councils (LHCs). There are three other significant departures from past practice: (1) the direct appointment of at least four members by the local authorities to whose area the territory of each health board has been matched; (2) the payment of chairmen; (3) the extension of representation of named professions to include nurses (this will be further extended to include other health care occupations as a result of the new proposals). Appointment by matching local authorities is a concession to long standing criticism of the undemocratic and self-perpetuating character of appointments. What has led to complications in the health board member's role is that the document already referred to, The NHS and the Community in Scotland, attempts, through its proposals, 'to interweave the representational and managerial elements'. (31)

At 31 March 1975, the term of office of approximately half of the 276 board members expired (appointments are normally for four years, arranged so that half the membership retires every two years). 'So far as possible the new appointments by the Secretary of State were made to achieve in each health board the pattern of membership
which had been proposed in the discussion paper'.\(^{(32)}\) The result is that about \(\frac{1}{4}\) of the membership on each board are local government nominees, two or three are trade union nominees, five have been nominated by the health care professions, one or two by universities and the balance (ranging from four to seven) have been nominated by other bodies.

Health boards, when established in 1974, were responsible for deciding on how many, if any, districts would be needed in each area. Factors which influenced the division of an area into districts included density of population, lines of communication, the organisation of existing health services, and the boundaries of local government districts.\(^{(33)}\) Ideally, 'the population comprised in a district should have a community of interest and a social coherence'.\(^{(34)}\) This is generally achieved if the district is coterminous with the proposed local authority boundaries.

Before commenting further on the district structure, mention must be made of the third layer of management below the district level. According to the official circular, the management structure within the district must allow for: (a) the management of institutions; (b) the management of particular professional groups such as nurses; and (c) inter-professional cooperation in programmes directed to the care of specific groups of patients or people generally.\(^{(35)}\) A further circular dealing in more
detail with management below district level in Scotland was issued in late 1975\(^{(36)}\). This was intended to provide health boards with the basic guidance they would need when they had to submit schemes to the Secretary of State for approval. The circular states that the first objective of management below district level is to ensure the smooth running of health service institutions and services and thus the day-to-day provision of health care to the public.

'Since management arrangements required to achieve this will differ widely according to circumstances, Departmental guidance can give only a general framework.' Managers below district level are responsible to a member of the district executive group (see below for a discussion of this concept), either directly or through second tier district officers.

Health boards have tended to subdivide their districts for management purposes on a geographical or, in certain cases, a functional basis. The subdivisions are called sectors and their managers sector administrators. The composition of sectors varies, but it normally consists of hospitals, health centres, clinics and related community health services. Exceptions to this are the largest hospitals which constitute sectors in themselves. Cooperation between the different disciplines below district level is also essential and this can be achieved through the creation of informal multi-disciplinary groups.

The subject of sector administration has been referred to as 'the neglected aspect of the management arrangements for the
It was this neglect, in part, which led to the setting up of a Joint Working Party under the Institute of Health Service Administrators (IHSA) in April 1975. Its report appeared in May 1976. The Working Party felt it was inevitable that the focus of public and professional attention should have been directed to the basic problems of reorganisation and the mechanics of integration. 'In the circumstances, it is perhaps not so surprising that (temporarily, we hope) little attention seems to have been paid to the role of the sector/unit administrator in the reorganised Service'.(38) Nevertheless, the Working Party felt that this lack of attention was unfortunate.

It is imperative..... that there should be an overall manager at local level who can evaluate the effect of change, who is accessible to both staff and patients, and who will always be available for advice and guidance. There must be someone to whom the public and Press can turn for immediate information. (39)

From an analysis of the circulars dealing with the management arrangements there would appear to be some truth in the report's assertion that management below district level has been neglected. Between 1972 and 1974 (the period of the Blue Band series of circulars) the only mention of sector and unit management was in circular HSR (72) C3. It was not until late 1975 that the circular discussed above appeared. Yet it can be convincingly argued that of all the management layers, sector administration is the most vital since it exists at the sharp end of the service where health care is provided. Because of the hierarchical
nature of the administrative structure in the NHS, administrators with ability and experience inevitably move upwards towards the top of the pyramid (ie district and area management). A health service administrator has described this process as producing a situation of 'the administration with the hole', the hole being at sector level.\(^\text{(40)}\) This problem is acknowledged by the Joint Working Party in its report. One of its main recommendations is that 'the career structure of the administrator should not become too heavily weighted in favour of the high management function'.\(^\text{(41)}\) If this occurs then the expertise that is required at sector/unit level will be lost. 'There are many whose aptitude and inclinations are best fulfilled by spending the major part of their careers at sector/unit level and it would be wasteful not to make full and proper use of their talents'.\(^\text{(42)}\) At present, administrators of little or no experience, of low status and possibly of low calibre fill these posts and perform the vital function of managing a service with doctors and others. The problem is that these administrators are not on an equal footing with consultants in hospitals and this can make communication between them difficult because a rapport is lacking. This problem was less in evidence in the previous structure. Many BoMs were close to the grass-roots whereas in the present structure the point of decision is further removed from the ground. Doctors are unsure of whom to approach over a particular matter: sector administrator, the DEG or the
AEG? Since the position of sector/unit administrators is an inferior one, doctors prefer in many cases to bypass them.

3.3 New Influences on Decision-making

Reorganisation of the Scottish NHS, as numerous official documents and circulars serve to testify, has largely been about improved decision-making through the adoption of a particular managerial style, namely, one in which officers exercise substantial executive responsibility on behalf of their boards in the interests of the boards and their services. In this way it is hoped 'to make the most efficient use of resources' and to 'give effect as far as possible to the rational priorities of the community as a whole.'

Executive management at area and district levels is vested in the medical, nursing, administrative and financial officers who collectively form area and district executive groups which are corporate authorities (ie they operate on a consensus basis, and on matters coming before them for decision they must reach unanimity). The purpose of an executive group at area level is to leave the board free to deal with 'major policy, strategic planning decisions, the broad allocation of resources and matters of substantial interest to the community.'

District executive groups (DEGs) are responsible for the administration of integrated primary care, hospital services and community services within a specified boundary. Although accountable to area
executive groups (DEGs), the intention is that DEGs should have a considerable degree of delegation.

In England, the district is considered to be of great importance to the planning system. The DHSS' planning guide\(^{(45)}\) claims that

> since most health services are delivered on a District basis, and most budgets are allocated within Districts, it is the District plan which will be the basic building block for the entire NHS annual planning system .... District plans will provide the basis for all annual planning in the NHS.

These comments may appear to be at variance with the view expressed earlier that the planning system will allow the DHSS to intervene to a greater extent than hitherto in NHS policy-making and priority-setting. The dilemma here can be neatly summarised by the phrase oft-quoted from the 'Grey book' that 'delegation downwards should be matched with accountability upwards'.\(^{(46)}\) However, these possible contradictions and ambiguities need not concern us here since they do not apply to the Scottish structure. What is important is the status given to the district in the English arrangements, which probably accounts in part for the non-existence of a line management relationship between district and area officers. The emphasis is different in Scotland. Health services are principally planned on an area basis. In the final analysis they are also managed on an area basis, with members of the DEGs being at all times the subordinates of their area counterparts. As one administrator commented in the interviews, control over the districts is 'much closer now than it ever was over BoMs.'
There is not so much independence or detachment'. This changed relationship has been a source of friction (47) and it is explored in more detail in the case study.

The officers comprising the area and district executive groups have a dual role to perform in the new management structure. Each has his/her individual responsibilities as an officer. But having become a member of an executive group he/she also assumes responsibilities of a broader nature relating to the service as a whole. Some of the problems associated with this dual role can be revealed more clearly if one examines the operation of accountability in the new structure. It has two aspects. First, there is the accountability of individuals - of the district officer to his area counterpart, and of the area officer to the board; second, there is the accountability of groups - the DEG to the AEG, and the AEG to the board.

There are difficulties in the accountability of individuals at the district level to their superiors at area. For instance, the district officer cannot be a member of the area officer's immediate team because he is in a different kind of relationship. He is, in the first place, not just an assistant to the area officer but a chief officer with his own set of responsibilities. Second, he is not near the area officer but is geographically separate; and third, his responsibilities are too weighty to be capable of daily adjustment with a 'superior'.

Greater problems arise when one looks at the relationship of accountability between executive groups. In the
previous two-tier system, as has been mentioned, BoMs were established as agents of RHBs and were responsible to RHBs for the management of hospitals. Immediate executive responsibility for the running of the individual hospital or group of hospitals rested with the BoM while the RHB's main concern was to facilitate the efficient administration of the group by advisory function rather than by executive action. The Farquharson-Lang report expressed the relationship thus: 'the functions of the two categories of Boards are therefore complementary;' the BoM exists 'to adjust the general administration of the hospital service to local conditions.'\(^{(48)}\) In practice this was a very woolly and confused kind of relationship of accountability since both authorities were boards of lay members possessing statutory powers. The new arrangements bear no resemblance to this structure. By comparison, relations between executive groups are stark and unambiguous. The official circular on these issues offers some guidance on the principles which apply to the delegation of powers to districts. The circular says that district management should be responsible to the executive of the board for providing the accepted level of service within an approved budget. Control over the district executive should be exercised by means of approved plans and financial budgets. 'The district executive should not normally refer to the AEG those decisions which it takes within its approved budget and in accordance with area policy.'\(^{(49)}\) ie decisions which do not involve a change in area policy, a major change
in the allocation of resources, or a major change in the services provided. This outline of the factors affecting relations between areas and districts begs several questions, eg how is the 'accepted' level of service determined? what is meant by 'approved plans'? when does a change in the allocation of resources become a major change? and when does a change in the services provided become a major change? As noted above, where there are statutory authorities at both levels (eg pre-1974 NHS) the lines of responsibilities can be blurred at the edges, but in the present structure the relationships, for purposes of accountability, need to be clear-cut. Moving towards the correct balance is a matter which is at present pre-occupying many boards (some authorities are even questioning the necessity of having districts at all in their particular areas). These structural and organisational issues inevitably have an influence on decision-making activities within health boards.

It can be argued that the district tier in the reorganised NHS constitutes the greatest test of the new management arrangements. This tier poses special challenges. The nature of the authority of the DEG is one such challenge. There is the difficulty of the 'acceptance' of decisions. Interviews with district personnel and others suggested that, in some cases, it has been difficult for DEGs to establish themselves as decision-making authorities, either internally with, for example, doctors, or externally with members of the public and public organisations. Although
the officers at area level also form an executive group, taking decisions in their corporate capacity, these officers are seen as being associated with the board, and as deriving their authority from the board (this is how the structure operated in the past at both levels - senior administrators both at BoM and RHB levels were associated with a board or a council and were seen as acting in its name and on its behalf). The decisions emanating from the area tier thus appear to be 'democratic' decisions and this helps to legitimise them and make them more acceptable to those affected by them. A DEG, on the other hand, is quite clearly dissociated from the health board. It is remote in the sense that it has its own separate headquarters and takes decisions in its own corporate capacity. This lack of status has not made life for the DEG any easier and it has led to individuals bypassing the district and going direct to the area authority.

The importance of the executive group concept should not be underestimated. It has resulted in significant changes in the way in which the health service is administered in each area and, in particular, in the role now played by board members in the decision-making process. The executive groups at area and district levels must operate as consensus teams. To some extent this development has formalised what was already happening in some authorities informally in the previous structure. However, it carries the process far beyond what went before. Prior to April 1974, chief officers meeting as a group had no formal
authority as a group. Decisions which required formal authority greater than that possessed by an individual officer had to be taken by the board. Under the new arrangements, however, the executive group is not just a number of officers putting collective advice to the board. The executive group itself is vested with a collective authority to take decisions. On the one hand officers formulate advice to the board on questions of policy, but on the other they themselves now take decisions, and on quite important matters. In addition, the executive group concept has enhanced the status of the nurse and treasurer in health service management. They are now equal members of the executive group alongside the doctor and administrator.

The significance of the executive group concept for decision-making activities may be more fully appreciated if the concept is examined in more depth. An alternative approach to the arrangements for management would have been to create two tiers of statutory authorities - area boards and district committees - and to provide each of them with sets of chief officers, without any reference to executive groups. In that event the health service would have had the kind of pattern with which it was familiar prior to 1974 - a statutory board or committee which was the decision-taking and coordinating authority. As was the case under the previous arrangements, each officer would have had a set of delegated powers. There would have been no delegation to them as a group. Decisions which were
important, either because of their magnitude or because they impinged on the interests of more than one chief officer, would have been referred to the board or committee and all chief officers would have had an opportunity to tender advice as to the action which should be taken. Again, as in the past, it could happen that the chief officers might have previously discussed the matter and had been able to agree on the advice which they should jointly put to the board. Or it could happen that they had not met, or had met and not been able to agree, with the result that separate bits of advice would be offered to the board.

The main point to emphasise is that because the item of business would have been considered by the board, it would have been dealt with in a situation in which all aspects could be brought together and conflicting interests reconciled. The former boards and committees not only took decisions but exercised, by their very existence, this powerful coordinating influence.

In the new structure, there are three decision-taking and coordinating bodies - the board itself, the AEG and the DEG - but two of these bodies are composed entirely of officers. The dual role that officers now have is a combination of an officer role with a role analogous to that of a member. The new management structure has altered the relationships between chief officers in ways which go beyond the limits of the consultations with which they were familiar before reorganisation. The executive group has a
corporate existence and a corporate responsibility. It has powers to take decisions which exceed the limits of individual chief officers. In the previous structure these group decisions would have had to be referred to the board. The executive group of chief officers may thus be compared with an executive committee of board members. In their capacity to take decisions the members of the group are playing a role akin to that of members of the board. It should be pointed out, however, that the decisions taken by executive groups fall within areas on which broad policy has been decided by the full board (e.g., a shift of emphasis towards geriatric care). Moreover, board members are fully entitled to question officers about decisions taken by executive groups.

Notwithstanding these checks and balances, there have been quite substantial changes in the operations of officers and board members, the result of which is that a great deal of decision-making lies not with board members (as it did prior to 1974) but with officers at area and district levels. The new management style has led to the creation of a system in which officers carrying major responsibilities are supervised by boards, instead of a system in which the concept is of boards assisted by officers. The new arrangement is a reversal of roles for board members and officers.

The executive groups are empowered to take decisions on behalf of the board. These decisions will commit the board just as positively as if they had been taken by executive committees made up of board members. The exceptional degree of delegation, which is the basis of the new relationship between members and officers, has contributed to the
role confusion experienced by board members, as the case study will show; and many members have found great difficulty in adjusting to this altered environment.

Development fund allocations illustrate the changes described above very clearly. A brief example may be given here for illustrative purposes. The extensive scale of delegation by the board to the chief officers includes authority to vary staffing establishments and create new posts. Authority to create a new post is delegated to the area or district executive group on the basis that, if funds are available for an additional post, all demands for extra staff must be taken into account. The responsibility is then on the members of the group, not, as before, to present a case to the board in their individual capacities and await their decision, but to agree the right decision among themselves. In short, the boards are concerned with principles and their officers give effect to these through a wide range of detailed decisions. It is physically impossible for the small number of health boards to take, or explicitly confirm, the same number of decisions as their predecessors did collectively. The fifteen health boards replace the 150 or so bodies previously responsible for the NHS in Scotland. Moreover, the number of lay people participating in NHS administration in Scotland has been reduced from over 1500 before 1974 to 276 since then. Thus, on any count, the points at which important decisions involving lay members are made with regard to the local operation of health services have been drastically reduced. There are now only fifteen key points of
decision-making which involve lay members.

With reorganisation, the role of board members has been confined to dealing with 'major policy (and) strategic planning decisions', while officers have delegated to them a wide range of powers to make decisions without having to refer them to the board for approval, as well as implementing those decisions which must be referred to the board. Even the strategic policy-making role reserved for board members will be largely influenced by the kinds of information supplied by officers. The effect of these changes is that the role of board members has contracted considerably, while the role of officers has greatly expanded. In practice, this could mean that lay members are 'restricted to a policy-approving and monitoring role, leaving detailed management and the formulation of policy' to officers (emphasis added; but see below). (52)

To seek an explanation for this change in operating practice, it is necessary to refer to the controversy surrounding successive attempts to make a clear distinction between policy and administration. Although the debate is a somewhat sterile one, since there is ample evidence in the literature to support the conclusion that it is quite impossible to separate the two activities in view of their interrelatedness; (53) this has not prevented enthusiastic reformers, often in the shape of management consultants or those with vast experience of private sector management practices, from indulging in numerous attempts to draw just such a distinction.
Recent endeavours to distinguish between policy and administration have their origins in the reorganisation of local government, the recommendations of the Maud Committee on the management of local government being particularly relevant. As Hill notes, the Committee 'was .... concerned about the undue involvement of councillors in day-to-day administration, so that .... they are unable to devote time to issues of policy'. The difficulties involved in trying to make a distinction are spelled out in the Committee's report which was published in 1967.

We do not believe that it is possible to lay down what is policy and what is administrative detail; some issues stand out as important and can be regarded as 'policy'; other matters, seemingly trivial, may involve political or social reaction of such significance that deciding them becomes a matter of policy and members feel that they must reserve to themselves consideration and decision on them. A succession of detailed decisions may contribute, eventually, to the formulation of a policy. (55)

It is precisely because policy and administration are largely inseparable that the official circular dealing with the roles of health board members and officers is vague. For example, it states that

the powers formally delegated to the executive group may vary from place to place and in practice some decisions involving few resources would be referred to the board because of their interest to the community generally whilst others involving greater use of resources but flowing naturally from decisions of principle made by the board would be taken by the executive group.

In effect, therefore, the circular admits that it is not really possible to make a clear-cut distinction between policy and administration. But the outcome of the attempt to clarify the respective roles and functions of board
members and officers, a process begun in 1966 with the Farquharson-Lang report ("only if boards concentrate their attention on the wider issues and delegate to officers the maximum degree of responsibility, while retaining their function of overall direction and control" will the best use of resources be achieved)\(^{57}\) has been a reduction in the contribution which board members can make to decision-making\(^{58}\) Because 'policy implementation 'feeds back' into policy formation'\(^{59}\) and is the basis of future policy, if board members are to be cut off from any involvement in this feedback stage (and they were involved in day-to-day management and administration before 1974), then any policies they approve will inevitably be heavily based on the advice and recommendations received from officers. What tends to happen in practice in such a situation is the exact opposite of what is intended, namely, that officers formulate the policy and board members argue about the technicalities of administering it\(^{60}\)

A safeguard incorporated in the new arrangements is that the executive group can only take a decision if there is unanimous agreement. It is a consensus group. Once a collective decision is taken each officer is committed to it. If an officer disagrees with other members of the group the matter has to be referred upwards for decision - to the board from the AEG, and to the AEG from the DEG.

A feature of the previous administrative structure was its 'committee-intensive' nature. This, as was noted in Chapter 2, was criticised by Farquharson-Lang who favoured
a simpler committee structure in keeping with the emphasis on the policy-making, as distinct from the executive, role of the lay member. 'We recommend that all boards should review their committee structure with a view to reducing the number of main standing committees to three or less, and to ensuring that any sub-committees are not set up to carry out tasks which could be better performed by officers.'

The new structure has implemented these recommendations. All the health boards have devised their own committee structures but, apart from slight variations, most boards have three standing committees: the main one is concerned with policy and resources (some boards have separate committees for these activities); another is concerned with general purposes (ie personnel, staffing, manpower planning); then there are the statutory Part IV committees for the various services, eg general medical, general dental and general pharmaceutical. Guidance from the SHHD on committees stated that 'the object should be to limit the number of committees as far as possible' and envisaged a policy and resource allocation committee and committees for Part IV services. Some of the standing committees also have sub-committees. The committee structure has proved a problem in many areas mainly because of the need to involve board members in decision-making. Some boards have established a second standing committee, apart from a policy and resources one, in order to involve those board members who are not on the policy and resources committee.'

In certain boards, there is no practical need for a second
committee, other than to make members feel involved in
decision-making, and it has sometimes been difficult because
of lack of business to draw up an agenda for a particular
meeting. In addition to this dilemma, one of the effects
of having a policy and resources committee as the major
committee of a board has been to concentrate business in
the hands of this committee and to limit discussion at full
board meetings. Since full board meetings are open to the
press and public, this may be a contributing factor to this
development, but it creates additional difficulties for
board members who are not on this important committee.\(^{62}\)

Two other new features of the reorganised NHS ought to be
mentioned in advance of presenting the case study. Both
come under the general heading of advisory bodies. A
feature of the NHS (Scotland) Act 1972 is that it specific¬
ally provides for the health board to be advised by the
consumers and by the providers of health care. Local
Health Councils (LHCs) have been established to represent
the public interest, and professional consultative com¬
mitees have been established by the various health care
professions to represent their views at national, area, and,
in some boards, at district levels. In the reorganised
NHS, advice will be much more 'purposefully channelled' and
will have a greater influence on health board decision¬
making than was the case prior to 1974.\(^{63}\)

LHCs stand outside the formal management structure of the
NHS. Their 'independence' needs to be qualified since
members are in part appointed by health authorities, who
also finance the Councils, and provide them with accommodation. LHCs can offer advice and suggestions on their own initiative and they are consulted by health service managers for their views on changes in services and on future plans and proposals. They have access to information to help them assess how well facilities in their district match up to recommended standards. They are able to visit health service establishments, and are required to submit annual reports to their health authorities. The effectiveness of LHCs depends largely on the calibre of those appointed to them and of the secretaries who service them, and on the relationship they have with health board officers, particularly at an operational level. To achieve the correct balance between representing the public view and, at the same time, appreciating and understanding constructively the problems faced by, and the constraints operating on, management is not at all easy. In addition, as was pointed out earlier, health board members are confused in many cases about what their precise purpose is. Feelings of vulnerability and superfluousness have been exacerbated by feelings of resentment against, and suspicion of, LHCs which, it is widely believed, are taking on functions which many board members think should rightly belong to them. Hence the existence of LHCs has further confused the role and purpose of board members and has led to some members questioning the relevance of, and need for, health boards.

The professional advisory machinery, representing the principal health care professions, has the function of
advising health boards and expressing the views of the professions both on policy issues and on matters of importance relating to the running of services. There is little doubt that the best organised professional advisory committees are the medical ones. The medical advisory structure (MAS) has its origins in two reports published by the SHHD. The main aim of the MAS is 'to provide a channel of access to management, to express a corporate medical viewpoint, and to provide a general background of accepted medical priorities'. The MAS provides the framework 'within which the necessary partnership between the professions and the management structure of the Health Service can be formed'.

3.4 Reactions to Reorganisation

This final section focuses on three areas, all related, which have given rise to much of the criticism levelled at the reorganised NHS: (1) an undue emphasis on management; (2) the confused role of board members: are they managers or representatives of the community, or a combination of both? and (3) problems arising from the consensus approach to management and decision-making. Other aspects of the structure have also come in for criticism, for example relations between local authorities and health boards. Obviously, if health boards wish to improve community services and lessen the demand on hospital care, then they are going to have to rely on the support and cooperation of those social services which remain under local authority control. 'The seriousness of this problem leads many
observers ... to conclude that another major reorganisation is inevitable within 25 years' time to complete the integration of health and social services which has just begun.(67) However, these matters need not concern us here since the case study does not examine the inter-agency dimension of health care provision except in an indirect way as another influence/constraint on the decision-making process within health boards.

In Scotland, the proposals for a revamped NHS were given a quiet, uneventful reception. It would be wrong to deduce from this that all NHS personnel and all members of the public are content with the way in which the new structure is operating. In fact, there exists a great deal of underlying frustration and hostility stemming from reorganisation. Much of this can, of course, be attributed to the trauma of coping with change, and the natural reluctance of people to see the status quo altered in any fundamental way, particularly if one occupies a position of privilege which is threatened by change. But it is possible to extract from the general malaise grievances and concerns which go deeper than merely superficial, and often temporary, 'gut reactions' against change.

Before examining some of these grievances, it is necessary first to try and explain why the Scottish NHS has not received, publicly at any rate, and also probably privately, the same hostile attention which has been directed fairly consistently at the English service. Part of the explanation might lie in the fact that since 1974 the NHS has been
exposed to all sorts of demands and pressures which have been felt more keenly in England than in Scotland. Those problems that come readily to mind are: nurses' pay, junior doctors' pay, pay beds and the role of private practice within the NHS, and resource constraints as a result of public expenditure cuts in the growth rate. All these difficulties have had a negative effect on staff morale and many have associated them with reorganisation in much the same way as people have associated local government reform with increased rates and poor services (whereas, in fact, inflation and cash limits were largely responsible).

According to Robert Maxwell, who was working for McKinsey and Co during the reorganisation period, each of the problems just mentioned has been more serious in England, than in the rest of the UK. As Chapter 2 noted, the Scottish NHS is more generously endowed in manpower, money, and physical facilities than the service in England, particularly in the Northern regions. Private practice is not a problem, with only approximately 300 private beds mainly located in the central belt. Scotland has also achieved a less elaborate reorganised structure by omitting the regional tier. 'In part ...... this is simply the result of (its) relative size - there is a good case for arguing that one should never reorganise a big entity in its totality, for the result will always be clumsy', writes Maxwell; and he continues, 'the NHS in England has been more tightly stretched than in the rest of the UK, and less successful (partly because its sheer size makes informal, personal
contact more difficult) in avoiding misunderstanding and conflict.\(^{(70)}\) The smooth process towards integration of the tripartite structure in Scotland seems to confirm Maxwell's analysis. Unlike England, there was only one Green Paper, no Consultative Document, just a White Paper and then a Bill. An editorial in *The Hospital*\(^{(71)}\) at the time wondered whether this fast and consistent progress in Scotland perhaps indicated that the permanent civil servants at the Scottish Office, rather than the temporary politicians, were the main motive force; and to a great extent this is what much of the devolution debate is about (ie Scotland already has administrative devolution but lacks political devolution). There are a number of other factors that could account for the different reaction in Scotland to reorganisation. The Scottish Green Paper received a reasonably enthusiastic reception, which was in marked contrast to the fate of the first English Green Paper. Both the Scottish Council of the BMA and the Scottish Association of Executive Councils gave their qualified approval. Only local government bodies, not surprisingly in the circumstances, were not keen on the proposals. Perhaps the secret behind the Green Paper's success was that unlike its English counterpart, it had been issued after, and not before, consultation with interested bodies.\(^{(72)}\)

A further reason for a more favourable response in Scotland may lie in the vagueness of the proposals which, once again, was in contrast with what happened in England. The
Scottish White Paper was almost as open as a consultative document and was not much more than half the length of the Green Paper (and less than one third of the length of the English White Paper).\(^{(73)}\) As noted earlier in this Chapter, many issues were left open for decision later. Even the circulars issued to give guidance to the shadow authorities were vague. One observer commented that whereas the English circular on the determination of districts read like the rules for a rather complicated game of patience, the Scottish circular\(^{(74)}\) was an interesting discussion of the issues involved with little attempt at advice and none at all at direction.\(^{(75)}\) The circular had the air of a detached observer. This vague, somewhat casual tone, is also apparent in the circular on cooperation and liaison between health boards and local authorities,\(^{(76)}\) according to which it was

\[
\text{neither necessary nor appropriate to attempt to specify in detail the machinery that should be adopted in each area to achieve the desired end: the aim of the White Paper (on Relationships with Local Authorities) is to indicate the general approach that should be adopted.}
\]

If the specificity and detail which engulfed the English proposals were lacking from the Scottish arrangements perhaps the explanation for this lay in the fact that no specific management study by a team of consultants was commissioned in Scotland. Legislation for the Scottish reorganisation was enacted prior to the Grey Book in England which was published in September 1972. The NHS (Scotland) Act received the Royal Assent in August 1972. The preliminary work for evolving the details of the new structure was carried out by the SHHD albeit with some
spillover from the DHSS (see below).

In the Scottish and English models, but more especially the latter, criticisms of reorganisation have centred on the emphasis on management and efficiency, and on the lack of democratic control and accountability which is deemed essential in a public service, particularly a major social service.

Several observers have expressed the view that the Scottish proposals are 'much more 'participative' in tone than the English ones'\(^{(77)}\). These participative elements include the appointment by the Secretary of State of the chairmen and members of the health boards after consulting professional, local authority, university and other interests; and the creation of statutory professional advisory committees at each level of the new structure.

According to another commentator, whereas the central objective of the new service in England was to be effective management, in Scotland a more imaginative stance, which may have reflected the oft-repeated views of the Chief Medical Officer, was adopted\(^{(78)}\). Hunter continues,

the remedy, even for escalating costs, was seen to lie less in managerial control than in a basic reorientation of the health service ... . The emphasis in Scotland was clinical not managerial .... . Reorganisation in Scotland had two aims both of which were patient-centred: (1) to integrate the personal health services 'round the patient' by developing a preventive community-based system of health care; and (2) to provide these integrated services within a unified but supportive system of management, operating in the context of a flexible, anticipative and partici-
pative planning process (79)

Nevertheless, despite such intentions, which have tended to remain implicit (rather than become explicit), Hunter accepts that the Scottish NHS perhaps shares some of the managerial overdose from which, if its critics are to be believed, the NHS in England is suffering. Certainly some of the difficulties emerging in the Scottish structure, particularly in the area of interpersonal relationships within executive groups and in the relationships between the two tiers (area and district), have their parallels in the South. Therefore, the reorganised Scottish NHS cannot be regarded as a totally separate entity from the English Service. The Scottish model, as Chapter 2 emphasised, has its distinctive qualities, but in a centralised governmental system such as that which at present prevails in Britain, it is inevitable that common elements should exist between the DHSS and the SHHD. Sir George Godber has remarked that 'if a comprehensive health service is to be maintained in Britain then that central influence must be maintained also' (80). He continues, 'the other Departments (ie Scottish, Welsh and Northern Irish Departments) depend to a greater extent than is generally disclosed on the Department in London for certain of the general activities which may be conducted on behalf of all of them ....'.

A great deal of criticism, both in England and in Scotland, has focused on the separation of management and representation, a theme emphasised repeatedly in Sir Keith Joseph's Consultative Document. Board members were to be appointed
for their management ability as individuals, not as community representatives. The latter role would be performed by LHCs (CHCs in England). In Scotland, where there was no Consultative Document, only a White Paper issued in 1971 after the Document had been distributed to English authorities, the emphasis on management ability was not stressed but, as Brown (81) has written, 'the difference between the English and Scottish proposals about the composition of the new bodies may be more presentational than real!'. This does not necessarily imply that Scottish health boards are primarily managerial (the discussion document published in 1974 tends to blur the distinction between management and representation) but rather that the English authorities are perhaps less managerial than Sir Keith originally intended them to be. Brown comments that 'for all the emphasis on management in the English document, it is hard to see how the membership of the new authorities will differ, except in size and number, from the old hospital authorities that were appointed on a similar basis'.

Nevertheless, the creation of predominantly managerial bodies is regarded by some people as a retrograde step. In interviews carried out by the author in the summer of 1973 as part of a small-scale research project on the reorganisation of the Scottish NHS, (82) doctors and administrators expressed a preference for a continuation of the mixed system (a combination of management responsibilities and representative functions which operated in the RHB/BoM
structure). This brought the consumer view to bear at the point where decisions were made and money was spent. This, it was maintained, was a better system than the creation of LHCs which are purely advisory bodies with no executive powers, operating outside the formal management structure, although there is a case for bringing consumer views to bear at the point where services are delivered.

A further managerial innovation, consensus decision-making, has also been viewed with some scepticism by those who are concerned about a lack of authority in the new structure, and the length of time taken to reach decisions. It has been argued that the creation of consensus teams was the only way out of the impasse resulting from professional intransigence over the desirability of a chief executive figure who would run the Service within each area in much the same way as local authority chief executives at present administer regional services. One of the difficulties over having chief executives in the NHS is the inability to agree on who would be eligible for such posts. Would it be a medical person (which is what the doctors want) or could it be someone with more general management skills (which is what the Farquharson-Lang report recommended)? Suggestions that chief executives would be supportive and facilitating rather than directive did not take the heat out of these difficulties.\(^{(83)}\)

Despite all the emphasis in the proposals for reorganisation on consensus management, multi-disciplinary teams and the need for 'delegation downwards', a number of commenta-
tors have argued that the hierarchical arrangements incorporated in the new NHS are inappropriate to the requirements of a modern health care system. Draper and Smart\(^{(84)}\) believe that structures of this type become rule-bound, inflexible, and insensitive to the needs of, and changes in, the world around them. They argue that administrative change, which is what reorganisation has been all about, does little to affect the real quality of health care for any group in the population. What is needed, they suggest, is an alteration in the pattern of social relations associated with the process of medical care. Such changes might occur more readily if the public had the opportunity to participate in preventing or alleviating health problems. A large proportion of the morbidity experienced in modern society is related to factors like smoking or alcohol consumption or to causes like accidents or occupational hazards, all of which could be tackled via greater public involvement in health care issues rather than through emphasising the role of professional managerial expertise in the NHS.\(^{(85)}\) In similar vein, Hunter\(^{(86)}\) sees criticism of reorganisation as a 'lament for lost opportunities'. In his opinion, an arena-negotiation model would have been more appropriate to a health care environment. It would have led to a structure which, in Dahl's words, 'encourages consultation, negotiation, the exploration of alternatives and the search for mutually beneficial solutions'.\(^{(87)}\)

Apart from the proposals themselves, critics also point to
the manner in which the new arrangements emerged and were implemented. Many people within the NHS were confused by the changes. Morale was adversely affected as people felt their careers to be threatened. Information about reorganisation in Scotland was obtainable through the Blue Band series of circulars, copies of which were distributed to all NHS bodies. In addition to this series, a bulletin was issued every two/three months by the SHHD under the title Integration. These bulletins had a wider distribution than the Blue Band series and were presented in such a way as to have a more popular appeal. The purpose of the bulletins was to keep all who were working in and for the NHS in Scotland in touch with progress towards 'the appointed day' (ie 1 April 1974). Material of a similar nature was disseminated in England.

A study by Brown et al.\(^{88}\) carried out in Humberside during the period leading up to the appointed day revealed that among staff there was a great deal of uncertainty about key features of the new management structure. The difficulty, the authors suggested, lay in the complexity of the proposals rather than in any lack of material. According to the study findings, although the general reaction to reform was a welcoming one, specific objections were voiced.\(^{89}\) A frequent criticism of the new Service was that it would be 'more bureaucratic'. For some the number of tiers raised the spectre of 'more chiefs than Indians'. Many regretted the disappearance of lay members from district management responsibilities. The remoteness of the management bodies
worried some as this would lead to depersonalisation.\textsuperscript{(90)}

Although no comparable study was undertaken to discover the views of those working in the Scottish NHS, many of the above comments and findings are equally applicable to the Scottish structure. For example, as was noted in the previous section, the numbers of lay people in the NHS have been drastically reduced. At the same time, the responsibilities of lay members have increased considerably, with the expansion of the NHS through the integration of the tripartite structure. These twin developments have led many to view the Service as insufficiently accountable (despite LHCs) and as officer-dominated.\textsuperscript{(91)}

It was noted earlier that criticism of the Scottish structure has been less strident and public than it has been in England. Usually, in Scotland, it is only when one speaks with doctors and others directly that misgivings about the new structure come to the surface. It is also significant that most health service administrators, whether lay or professional, are less critical of the structure than those who are providing services directly to patients. The comment, 'it's early days yet', was an oft-repeated one when interviews with administrators were being conducted. If there were misgivings about some aspects of the new structure, most administrators were convinced that most of them would correct themselves once the structure had settled down.

Apart from academics and those providing health services,
criticisms of the Scottish structure have come mainly from the Scottish National Party (SNP), with rather more subdued criticisms coming from the Conservative and Labour parties. The SNP have drawn attention to what they believe is a 'top-heavy bureaucracy' in their policy document on the future of the NHS in an independent Scotland. The document argues that reorganisation has led to 'growing disquiet and scepticism (which) have been occasioned by the increase in administrative staff and costs, and the vast proliferation of committees at every level and of every kind'. It goes on, 'the present three-tier structure (SHHD, area boards, district groups) can, and often does, lead to duplication of effort, increase in paper-work, indecision and delay; scarce resources are diverted away from patient care'. The document believes that 'simplification of the system is required' and it proceeds to outline a possible alternative structure to the present one. The SNP reforms are aimed at removing the NHS from the vicissitudes of the political arena, and at simplifying the present administrative structure by abolishing one tier.\(^{(92)}\)

Some Labour MPs, for example John Mackintosh, have expressed unease over the 'top-heavy bureaucratic structure which exists within .... the health service'.\(^{(93)}\) It seems likely, therefore, that changes in the Scottish NHS will occur if devolution becomes a reality and an elected Assembly is established in Edinburgh. What happens to the NHS in England may also be dependent on devolution to the English
regions. While the government remains unenthusiastic about devolution within England and intends waiting until the Royal Commission on the NHS reports before commenting further on the subject, elements within the major political parties are in favour of changes along devolutionary lines which would have obvious implications for the NHS in England. As for the Royal Commission itself, it is unlikely to recommend radical change. Most likely it will propose some administrative tinkering, eg merging multi-district areas into single-district areas, directed towards improving the performance of the current management arrangements.

It should be pointed out, in conclusion, that among those who are critical of particular aspects of the reorganised NHS, many are in favour of an integrated service. Therefore, to this extent, the present structure for all its flaws is clearly an improvement on what existed before.

3.5 Conclusions
The purpose of Chapters 2 and 3 has been to lay a foundation upon which the case study can rest. Background on the development of the Scottish NHS, particularly on its reorganisation, is essential if the operations of the new health boards and those involved in administering services are to be fully understood and appreciated. Since the case study is concerned with a narrowly defined area of decision-making, it is even more necessary to provide an adequate context within which to locate the study.
The environment within which health authorities and health service personnel operate has to a large extent been, and is still being, shaped by the events of April 1974. Many current working practices have been shaped by the reorganisation proposals and debates (although most have a considerably longer history). Hence Chapters 2 and 3 have dwelt on this period of the Scottish NHS' history. The analysis has focused on developments of an institutional, structural type, although developments not of this type have occurred which are also of direct relevance to the subject-matter of the case study. For example, recent years have witnessed quite severe cutbacks in the growth rate of the NHS. These have had an impact on decision-making activities in the area of improvements and expansion (ie developments), which is of central importance to the study. They reveal vividly the sorts of ever-changing pressures to which decision-makers are subject in a fluid, often unpredictable, environment such as that which exists in the NHS. How administrators and others cope with these sudden climatic shifts, and the strategies and tactics at their disposal, to manage such uncertainty are major concerns of the case study.

The main criticisms which have been made of the NHS reorganisation have been referred to in this chapter. It is not the intention here either to agree or disagree with these criticisms. They have been commented upon because the climate within which health service personnel perform their tasks is affected by the image held of the service both by
such personnel and by the public. Many employees and professionals working in the service share misgivings about the new structure, therefore it is necessary to mention some of these since they can have a bearing on decision-making processes, eg the kinds of relationships which might develop between individuals, whether information is circulated freely or withheld, whether communication channels remain open or are obstructed, and so on. Some of these issues will be taken up in the case study which attempts to view decision-making from the standpoint of the participants themselves, as well as to provide some insights into the operation of the new management structure.

Chapter 1 introduced the concept, policy triad, to provide a framework for the case study and its description of decision-making. The triad, to recall the discussion in Chapter 1, is made up of three groups: board members; officers; and advisory groups (providers and consumers). These broad groupings do not necessarily share common interests and/or aims. But for the purpose of highlighting those actors who are involved in the decision-making process to be described in Part 3, it is convenient to refer to them collectively as forming a policy triad. This chapter has described the emergence of the triad as a central component of reorganisation. It reflects many of the new influences on decision-making in addition to many that were inherited.

This chapter has touched briefly on a number of tensions present within the decision-making environment, eg relation-
ships between areas and districts, and between board members and officers. Some of these have their origins within the reorganisation proposals, while others have emerged since the implementation of the proposals. Tensions arising from interpersonal relationships between officers, and the operation of the four-tier structure (SHHD, areas, districts, and sectors), might disappear over time (possibly in some boards rather than in all of them). But there is no reason to believe that all the tensions can be so easily smoothed away, and dismissed as temporary aberrations in what is essentially a 'rational' structure, since they may reflect quite fundamental defects in the design of the structure. Whether these distortions were inevitable for political reasons (the final set of proposals to some extent reflected a compromise between different, and conflicting, criteria)\(^{(97)}\) or because the designers did not pay sufficient attention to the political dimension of the decision-making environment, the outcome has been the emergence of tension points which are not conducive to the pursuit of rational decision-making (a central theme of reorganisation). The case study is concerned with identifying these tensions in the context of a particular decision process and its aim is to discover how those working within health boards handle them.
The desirability of a theoretical framework underpinning the case study should not require stressing. Heclo, for instance, has argued that case studies of policy should be distinguished by their theoretical perspective, for without such perspective the study is at best an interesting contribution to historical scholarship and at worst an uninteresting, episodic narrative.

He is critical of Chapman's study of decision-making for merely chronicling 'in detail the actions and movements of participants' and for not offering any 'broader conclusions except that "the case itself should be a contribution to knowledge"'.

The chapter is in five sections. The first section presents a frame of reference within which to locate the theoretical discussion that follows. A second section is concerned with defining the term 'decision-making' and confronts problems posed by the notion of 'non-decision-making'. The third section reviews theories of decision-making, primarily synoptic and incremental ones, for their usefulness as aids to understanding phenomena, while a fourth examines an orientation to social science research which attempts to overcome the limitations of any particular model or theory. Finally, a concluding section draws together the main themes of the discussion.

4.1 A Frame of Reference

The frame of reference is derived from the work of Snyder,
Bruck and Sapin\(^4\) who developed it for their study of foreign policy-making. Essentially, its usefulness in the present context lies in its structuring of the environment (ie the allocation of development funds in two health boards). Moreover, it is not concerned with what values should govern policy decisions since such an orientation would probably shed little light on what values do in fact govern and how. As far as the present research is concerned, it is the what is which is of interest rather than the what-ought-to-be. The frame of reference comprises five foci:

1. The characteristics of the unit of decision. Who are the major participants and what are their roles?

2. The elements of the organisational context in which a decision takes place. How formalised are the relationships among members of the decision unit? Are there formal rules and procedures that guide their deliberations? Or is there little formal structuring of interactions within the group?

3. The characteristics of the setting in which the unit of decision must operate. What scope will the decision have? Is the immediate environmental context in which the decision must be made likely to affect the nature of the decision? Must the decision be made in a matter of minutes, hours, or days? What limitations, internal and external, are there on decision-making?

4. The origin of the decision-making situation. Was the decision forced upon the decision-makers, or did they themselves initiate concern for the issue at hand? Does the situation call for specific action or would continued inaction be an acceptable alternative?

5. The pattern of motivations characterising the decision-making process. What do the decision-makers consider to be the goals of the decision-making unit itself or of the organisation for which the decision must be made? What personal motivations do the decision-makers individually bring to the process of selecting a course of
action? What high priority values or norms do the decision-makers see as being involved in their decision?

The frame of reference is built around the concept of the unit of decision, an analytical device to allow identification and isolation of the actions and activities which are of concern to a researcher (in the present project, those arising from the allocation of development funds). Not all members of groups or departments are likely to be involved in a particular decision-making process; for instance, it would be absurd to include every clerk and typist working in a health board in a case study investigating the allocation of resources. For different problems, different members of particular departments will participate in decision-making. It is necessary, therefore, to establish the boundaries which encompass the actors and activities to be observed and explained.

The decision-making event under observation occurs in an organisational context. To ignore this context, claim Snyder et al, is to omit a range of factors which significantly influence the behaviour of decision-makers, including not only the critical problem of how choices are made but also the conditions under which choices are made. Decision-makers do not perform in a vacuum but operate within an organisational system comprising a particular sequence of activities and structure of relationships. These activities and relationships are 'the outcome of the operation of formal rules governing the allocation of power and responsibility, motivation, communication, performance
of functions, problem-solving, and so on."(6)

The institutional setting is important because the behaviour of a decision-maker in a decisional unit is largely conditioned by the directives, rules, precedents, and ideologies of the institutions, or their subdivisions, of which he is a member. The limitations on decision-making also need to be considered. These include problems of information (ie its availability, the purposes, if any, to which it is put, and by whom), time, and other constraints imposed by the internal and external setting which can help to shape the decisions that emerge. There is no need to dwell on these constraints here because they are explored in more detail in Chapter 13 in the context of the allocation of development funds in two health boards.

The origins of decisional units are of significance. Snyder et al state that the empirical questions underlying the concept are: who becomes involved in a decision, how and why? How does the group of officials (decision-makers) whose deliberations result in decision become assembled? The authors note two methods of unit construction: automatic assignment and negotiation. 'The personnel and activities which we analytically call the unit are specified and established within the total decision-making structure by these two methods!'(7) The formal roles of the actors provide a means of knowing whether they will be part of the unit. Also there are standing units, that is, committees or groups who are expected to act on given matters (eg health board standing
committees). Negotiation occurs in cases where no routine procedures exist, or where new conditions require a special procedure (e.g., the presence of a chairman of an advisory committee at a meeting of an area executive group).

Motivational analysis involves 'very thorny problems indeed',(8) which arise from the difficulty of probing decision-makers' motives and reasons for acting in particular ways. There has been no attempt in the present research to probe perceptions, values, or attitudes through the use of psychological techniques of which the researcher has no knowledge or experience. Nevertheless, it is important to acknowledge the presence of motivation as one element accounting for action, or inaction.

Following Snyder et al, the case study is concerned primarily with 'why' questions: why does the actor/do the actors act, that is, why does a decision get made? why does action take the particular form that it does in a particular situation? why do patterns of action evolve from decision-making? It is necessary to suggest some of the basic kinds of data from which motivations have been inferred (see below). Members of a decision unit are motivated by the responsibilities and objectives of, in the case of health boards, the NHS structure, or any part thereof. These, of course, will differ depending on whether the actors are lay administrators, professional administrators (e.g., medical officers, nursing officers), doctors, nurses, and so on. Snyder et al.(10) suggest three related types of data which might be helpful in tracing motivation-
al factors:
- Training and professional or technical experience inside or outside the decision-making organisation - the perspectives and judgements of the decision-maker will be affected by whether he was trained as a doctor, a nurse, an administrator, an accountant, or whatever, and by whether he is a generalist or a specialist, a lay member or an expert.
- Continued professional affiliations - if, for example, a medical decision-maker retains a close intellectual association with other medical professionals outwith the decision unit, it is likely that he will share some of their value orientations.
- Working theories of knowledge - these refer to ideas, concepts and formulae concerning human nature and behaviour which circulate in any given culture and which may not be inculcated through specialised training and experience, but are absorbed in normal socialisation processes. For example, many decision-makers appear to believe in intuition as the basis of knowledge and reject the value of systematic analysis. The case study provides some evidence for this view.

In the present research, these data were obtained through unstructured interviews with decision actors\(^{11}\) and this material is presented in Part 3, principally in Chapters 7 to 9, but also in Chapters 11 and 12.

4.2 Decision-making and Non-decision-making

The making of decisions is a fundamental part of every human activity and, at its simplest, decision-making may be perceived as the selection of one specific course of action from among two or more alternatives, that is, as a process involving some kind of choice. The adequacy of this view has been challenged in some of the more recent literature which has focused upon the notion of a 'non-decision'.\(^{12}\) It is worth exploring this concept a little further since, as will be shown in Part 3, Chapters 11 and
12, the constraints operating on the decision process were such that a very narrow range of options was in fact open to decision-makers. Therefore, non-decision-making might be a better term to describe what was happening than decision-making, if the latter is taken to mean the freedom to select a particular course of action without being subject to numerous constraints which serve to restrict the choices available. Dubin\(^\text{(13)}\) has summarised the argument well:

> Decisions are made to guide the course of human action. Two general outcomes of decisions are possible: 1) to select a new course of action different from that being pursued; and 2) to choose the present course of action as the best among available alternatives, thus continuing ongoing activities unchanged.

Dearlove,\(^\text{(14)}\) in his study of policy-making in one local authority, concludes that the decisional activity he observed was restricted 'to the making of routine decisions involving the maintenance of established commitments...'. As this statement suggests, non-decision-making, which is basically what Dearlove means in his use of the term 'policy maintenance', can be included in definitions of decision-making. In fact, following the work of Bachrach and Baratz,\(^\text{(15)}\) Parry and Morriss\(^\text{(16)}\) argue that non-decisions are decisions. They are not, however, necessarily the sorts of 'key decisions' studied by the 'decisional approach' associated with the work of Dahl and his associates. Many are lesser decisions which are component parts of a routine and the power which a routine reflects may be of a different kind to that discovered by the analysis of decisions.

In essence, Parry and Morriss advocate a decisional approach to non-decisions whereby the definition of a non-
decision begins by stating that it is a decision. This extension of the term decision-making to include the notion of non-decision-making is useful if one is attempting, as is being done in the present research, to penetrate a particular decision process in order to understand more fully precisely what is involved, i.e. to see which of Dubin's decision outcomes best fits the decision process observed.

The political nature of decision-making was noted in Chapter 1, although it is necessary to be clear about what is understood by the term 'political'. While one would agree up to a point with Klein\(^{(17)}\) that 'politics are ... about the reconciliation of conflicting interests' (emphasis added), the definition is misleading if this is all that is embraced by the term. Politics are also about the operation of routines and standard operating procedures (SOPs). As Parry and Morriss, among others, point out, decision-making of this routine variety is a neglected part of politics. They believe that while politics are a matter of decisions and choices, they are also 'a matter of customs and regulations ...'.\(^{(18)}\) These 'routines may be procedures leading up to decisions or may be decisions themselves'.\(^{(19)}\) Indeed, Parry and Morriss go as far as to propose discarding the notion of 'non-decision' on the grounds that 'most - though not all - so-called 'non-decisions' can be seen to fit into the category of decisions'.\(^{(20)}\)

In their discussion of routines and SOPs, Parry and Morriss
draw on the work of Sharkansky\(^{(21)}\) and Lukes.\(^{(22)}\) In his analysis of power, Lukes is anxious to show that non-decision-making need not involve 'actual, observable conflict, overt or covert'\(^{(23)}\) which causes him to depart from Bachrach and Baratz's views on power, decision-making and non-decision-making. According to Lukes,\(^{(24)}\) 'A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influencing, shaping or determining his very wants.' This agenda-setting role has received insufficient attention in studies of decision-making. For Lukes,\(^{(25)}\)

the trouble seems to be that both Bachrach and Baratz and the pluralists suppose that because power, as they conceptualise it, only shows up in cases of actual conflict, it follows that actual conflict is necessary to power. But this is to ignore the crucial point that the most effective and insidious use of power is to prevent such conflict from arising in the first place.

Lukes continues:\(^{(26)}\) 'to assume that the absence of grievance equals genuine consensus is simply to rule out the possibility of false or manipulated consensus by definitional fiat'. One need not go so far as to agree entirely with Lukes' own three-dimensional view of power, which 'allows for consideration of the many ways in which potential issues are kept out of politics, whether through the operation of social forces and institutional practices or through individuals' decisions'.\(^{(27)}\) But what is valuable about Lukes' analysis for present purposes is his attempt to perceive non-decision-making as an activity which can occur through organisational routines, and
through social forces operating outwith the particular system being observed. In short, the absence of conflict should not be equated with agreement. As the case study will reveal, decisions on the allocation of DF involved few clear instances of actual conflict and emerged from a mix of precedent and organisational routines. Moreover, many of the constraints operating on health boards' allocating DF did not arise from within the health service but arose elsewhere. In many cases particular allocation decisions were the outcome, perhaps indirectly, of decisions taken by local authorities which had nothing specifically to do with health care decision-making. The adherence to routines within the decision process observed was a combination of elements of Lukes' definition of power and, and this is where the discussion departs from Lukes' view, of puzzle¬ment on the part of decision-makers as to what they should be doing and how they should be doing it. Heclo\(^{(28)}\) for instance, maintains that references to competing claims should not be taken to imply that all, or even the predom¬inant feature of, social politics is conflict and the play of power. Because the issues faced in social politics are so complex, the major difficulty may be not the exercise of political will, but the determination of what that will is, or ought to be. In other words, as was noted in Chapter 1, the situation confronting decision-makers may be less one of competing for power and more one of coping with uncertain¬tainty, or the 'possibly unwinnable dilemmas of social pol¬icy'.\(^{(29)}\)
Heclo's view of power and decision-making would appear to be of some relevance to the decision process observed in the two health boards. While the power factor may have had a bearing on the process, in particular the relationship between administrators and health care professionals, perhaps more in evidence were the constraints and uncertainties surrounding decision-makers in a setting where there are no clear measures of output or performance. In any case, output measures such as inpatient admissions, or days of care, are, as one commentator has written, 'conceptually inadequate when what we ought to be discussing is the tangible contribution made to people's health'. Qualitative measures of this kind, however, are notoriously difficult to devise. In the words of one health board Secretary, it is 'extremely difficult, if not impossible, to say that additional input X led directly to improvement in health status Y'. Allied to this is the difficulty of actually knowing when an objective has been met; for example, what level of service provision constitutes an adequate level of care for the elderly? Or when is it possible to say that enough has been provided in the way of services for the mentally disordered? Heclo expresses the dilemma succinctly: 'social politics arises because men disagree among themselves, but also because they do not know what to do or how to do it'. To this extent, policy results - it does not get made Rivlin comes to a similar conclusion in her claim that social problems remain unsolved
because we do not know how to do it ... The difficulties do not primarily involve conflicts among different groups of people, although these exist. Rather, current social problems are difficult because they involve conflicts among objectives that almost everyone holds.

A study of decision-making, including the notion of non-decision-making, from such a perspective may be conveyed by the term administrative politics.\(^{(36)}\) According to Self,\(^{(37)}\) 'administrative politics revolve around the discretionary decisions of administrative agencies or departments'. There has been an expansion of these with the growth of public agencies and, it might be added, the managerial bias of much recent reform in the public sector, including the reorganisation of the NHS, which has tried to exclude political considerations and has transferred much specific policy-making to the administrative arena.\(^{(38)}\) Self notes that because 'public administration has become a patchwork quilt of complex relationships and numerous decision points, on which new forms of politics are brought to bear',\(^{(39)}\) administrative politics flourish. Later sections of this chapter will return to the issues raised here.

Having established that the term decision-making can be used to include non-decision-making (on the basis that to do nothing is still the outcome of choice), and that it refers to the routines and SOPs, which collectively form a system of administrative politics, adopted by administrative agencies, partly in response to power relations but also in response to uncertainty, it remains to examine theories of decision-making, their relationship to the frame of reference outlined earlier, and their ability to highlight the issues
with which the frame of reference is concerned.

4.3 Theories of Decision-making

In the literature on decision-making, the study of the act of choice has focused on: (1) the origins of the decision (where the issue that had to be resolved originated from); (2) the procedures by which the decision was made; (3) the influence of the background of the decision-makers themselves on the choices they make; (4) the influence of the institutional or organisational environment on the decision; and (5) the content of the decision itself. Different theories of decision-making have highlighted some of these variables at the expense of others.

Both the frame of reference outlined earlier and the concept of administrative politics direct a researcher to an exploration of the internal mechanisms of organisations which does not simply focus upon the action, or inaction, of individual decision-makers but also upon their interaction with the organisational environment of which they form a part. Such a perspective leads naturally to an examination of incremental theories of decision-making to ascertain their relevance for providing insights into, and helping to account for, the way in which a particular decision process proceeds as it does. However, a discussion of incrementalism cannot precede consideration of rational theories. Although the emergence of incrementalist theories was, in part, a reaction to the rather monolithic, mechanistic and one-dimensional approach of the rationalists who were primarily concerned with how organi-
sations should function rather than with how they in fact operated (had they paid some attention to the latter, it might have enabled them to comprehend the lack of success of their management techniques when applied) rational theories are also relevant in furthering an understanding of organisational phenomena. Reference to them is unavoidable if for no other reason than their persistence among organisational reformers (eg management consultants).

It was observed in Chapter 3 how the pursuit of rationality was instrumental in the design of the NHS management arrangements. Self noting 'the managerial belief in paradigms of rational decision-making', has argued that organisations may need to be drastically changed to facilitate the rational approach, an example being the Maud proposals for streamlining the roles of councillors and officials in English local government. The same applies to the changed relationship between health board members and officers in the reorganised NHS, a consequence of a commitment to a managerial (ie rational) model of reform. As Self makes clear, 'it does not follow that .... managerial ... aims are intrinsically 'wrong' but that the results of such reforms may not accord with expectations'. It is at the interface of rational theories (which largely govern the present structural shape of the NHS) and incremental theories (which can account for departures from rationality and for distortions of the management structure) that many of the tensions described in the case study arise.
The outcome of this brief discussion is the necessity to explore from different perspectives, that is, the rational, the incremental, and the different dimensions within each, the various tensions and conflicts which can arise in a decision process. In this way a more thorough appreciation of organisational processes, as these affect decision-making, may be achieved.

Rationality

Although the classical theorists of rationality (from Taylor's 'scientific management' to Simon)\(^\text{(44)}\) are somewhat discredited in much current organisation theory literature, 'many management experts who advise governments today use a somewhat similar approach and assumptions.'\(^\text{(45)}\) Moreover, a rational model of decision-making, as Cornford\(^\text{(46)}\) has written,

\[
\text{may not yield a satisfactory account of the policy process, but it is nevertheless part of it, since it underlies the public language in which politicians must argue and provides the legitimation of their bargains from whatever motives and interests these result.}
\]

Cornford suggests that\(^\text{(47)}\)

\[
\text{even if every ... official cared only for the advancement of his personal ..., or bureaucratic interest, even if all policy represents a compromise among those interests, (he) would still be obliged to argue in the language of (a rational model) of the national interest (since some approximation of the model underlies much of (his) own understanding and judgement of politics).}
\]

The rational model may be said to be relevant in analyses of decision-making for four reasons: (1) many administrators believe they act rationally and that decisions they make are rational; (2) the model is useful as an ideal to
which many decision-makers aspire, consequently it permeates their thinking to some degree and possibly governs some of their actions; (3) rationality is a legitimising characteristic - it 'provides the legitimisation of .... bargains from whatever motives and interests these re-

sult'; (48) and (4) concepts derived from the model can account for the particular structures inhabited by decision-
makers.

'Synoptic' and 'rational-comprehensive' are other terms which have been given to the rational model. The model is based on three stages which are considered to be necessary in the realisation of a rationally calculated decision: (1) the decision-maker considers all of the alternatives (courses of action) open to him; (2) he identifies and evaluates all of the consequences which would flow from the adoption of each alternative; and (3) he selects that alternative the probable consequences of which would be preferable in terms of his most valued ends.

Above all, a rational decision entails clarity, and agree-
ment, about goals and objectives, and a search for the best possible means of attaining them. Every possible strategy should be reviewed, so that the best can be selected, and decision-makers should guard against undesirable side-
effects by studying all the possible consequences of each.

The development, and application, of management techniques like cost-benefit analysis, programme-planning-budgeting, management by objectives, operational research, corporate planning and, more recently, zero-based budgeting illustra-
tes the successive attempts by reformers to find ways to
bring decision-making more in line with the rational model.⁴⁹ Although these techniques are supposed to enable a rational choice to be made among a range of alternatives, in fact, as Edwards III and Sharkansky confirm, few of the techniques make an impact on actual decisions for the simple reason that 'the demands of rational analysis are simply too great despite the sincerest efforts to achieve it'.⁵⁰

Ideas associated with rationality, and some of the techniques stemming from it, have been incorporated into the management arrangements of the reorganised NHS. For example, the uplifted role of the Treasurer is significant in this respect since he is entrusted with the task of introducing, and applying, many of the techniques associated with rationality, such as management accounting, position statements, and output budgets. There is also an attempt in the NHS to shift the emphasis from a concern with inputs to a concern with outputs as decision-makers strive to utilise resources more efficiently and effectively. In the case of the medical profession, where interference by administrators is resisted, Community Medicine Specialists (CMSs) are expected to inject some rationality into decisions taken by doctors at the sharp end of the service. The training of CMSs places considerable emphasis upon the measurement of need and cost, and upon the assessment of priorities through epidemiological methodology.⁵¹ Despite the availability of a battery of techniques, serious doubts have been expressed as to the ability of CMSs actually to shift priorities with-
in health authorities.\footnote{52} A third instance of the application of rationality in the reorganised NHS concerns the creation of consensus management teams whose task it is to examine the needs of the service comprehensively in a corporate fashion, and then act unanimously.

The emphasis on management in the reorganised NHS, as was argued in Chapter 2, was a manifestation of a commitment to rationality, which was itself the outcome of a desire for a more efficient, and effective, use of resources. In this respect, it is worth making a distinction between, on the one hand, the activity of management, and, on the other hand, the activity of administration. Not too much ought to be made of this distinction, which is referred to again in Chapter 8, since both terms are, in practice, used interchangeably.\footnote{53} However, for analytical purposes, such a distinction can usefully illuminate the subtle differences between the practice of administration since 1974 with what occurred before then. Administration is a more limited form of activity than management and is less concerned with advocating change than with implementing policy and achieving stability through the maintenance of existing practices and procedures. Management, however, is more about promoting change, a conception which has some validity if the stress on this activity in the NHS since reorganisation is viewed as being motivated primarily by a desire to plan the service so as to enable quite dramatic shifts to occur in health care policy, in particular a shift from hospital-based to community-based care.\footnote{53} This is not to
suggest that administration can never be about change but to argue that when it does lead to change then it spills over into management. In short, administration refers to the operation of routines within a prevailing infrastructure of health service policies and institutional arrangements, while management refers to attempts to alter the infrastructure. In its application, the practice of management, or rather its outcomes, may differ little from the practice, or outcomes, of administration but this does not invalidate the theoretical distinction being made here between the two activities, each of which demands particular skills and approaches to decision-making, and each of which raises certain expectations as to what decision-making should entail. In the discussion of these terms in Chapter 8, management is described as being about strategic policy-making, while administration is described as being about the implementation of decisions.

A rational model, as Allison (54) among others, has suggested, presupposes the existence of a consensus within an organisation, among those involved in taking decisions. The commitment to consensus management within the NHS is an illustration of a belief in rationality which underlay much of the thinking about reorganisation. Basically, the greater the degree of rationality in a decision process, the greater the emphasis on consensus, on harmony, on a corporate approach to decision-making and on 'technical' criteria for the evaluation of proposals; conversely, the less the degree of rationality, the greater the emphasis on
political 'wheeling and dealing' and incrementalism.\(^{55}\)

Allison's rational actor model (RAM) sees choices in any field of decision-making as being clearly defined and based on rational assessments of public desires - it is simply a matter of fulfilling well-defined goals in an optimal manner. Decisions taken within the framework of the RAM, reflect a single, coherent and consistent set of calculations about particular problems. The possibility of organisational and political complications fouling the smooth-running machine simply do not enter into the model's orbit, largely because rational models are normative and prescriptive rather than descriptive. Nevertheless, although of limited value in illuminating how decisions are taken, and although inclined to obscure rather than to reveal, an appreciation of rationality can further our understanding of the operations of organisations provided one is aware of other ways of looking at decision processes. As was noted above, the present structure of the NHS is largely derived from rational theories. These assume a unitary view of organisational relationships (hence the emphasis on consensus) within the service, and that all those making decisions identify with, and share in, a common, super-ordinate goal, that is, the welfare of patients. Tensions, or clashes of interest, are perceived as irrational and are defined as 'technical' problems, for example, a failure in communication, poor information, and so on. This line of reasoning lay behind much of the diagnosis of the problems which were alleged to exist within the pre-1974 model of the NHS, in particular
the lack of coordination between the three arms of the service. (56)

Dimmock and Barnard (57) have commented on the degree to which assumptions of a unitary perspective permeated the reorganisation of the NHS, particularly in the adoption of the concept of consensus management by multidisciplinary teams. Yet, as the authors are well aware, the true picture to emerge from the upheaval of reorganisation is more complicated. Dimmock and Barnard (58) observe that

the service appeared to espouse the simple unitary view that the objective of Reorganisation, though about management, was in the interests of the patient ... (But) the outcomes (of the new arrangements) were significantly influenced by the need to reconcile conflicting interests rather than by some sense of an optimum structure determined by the patients' needs.

Moreover, the unitary perspective 'has denied the existence of sectional interests and in consequence, has largely failed to provide an accurate description of inter-group relationships within the service or relationships with the external environment'. (59) The authors advocate an alternative perspective with which to view the NHS, one which acknowledges the pluralism of such organisations where groups co-exist, each having its own objectives. To pursue this further, it is necessary to introduce incrementalist theories of decision-making.

**Incrementalism**

Incrementalist theories of decision-making are most closely associated with the writings of Lindblom (60) The 'strategy of muddling through' is directed towards the solution of
immediate, pressing problems rather than with the realisation of some goal. Muddling through attacks these immediate problems incrementally, that is, through a consideration of alternative policies which differ marginally from current policies. This immediately restricts the number of alternatives considered, making the problem of choice more manageable. Choice may be aided, too, because prediction of the consequences of these marginal changes may be more feasible and it may also be easier for decision-makers to evaluate a range of policies where these involve only marginal change from the existing base-line. Therefore, progress is made through a continual process of 'partisan mutual adjustment'.

A further characteristic of the strategy is that analysis and decision-making are seen as fragmented activities, undertaken by different agencies in a disjointed manner, hence the term 'disjointed incrementalism'. The notion of 'disjointedness' also has a secondary meaning which, as the case study will show, is of greater relevance for the present research. Braybrooke and Lindblom\(^{(61)}\) state that decision-making may be disjointed in a secondary sense because of its focus on 'remedial policies that "happen" to be at hand rather than addressing (itself) to a more comprehensive set of goals and alternative policies'. However, insofar as there were observable divisions between area and district tiers in the two health boards, which hindered efforts at synoptic problem solving at area level, then elements of the primary meaning of 'disjointed' were also evident.\(^{(62)}\)
In his analysis of decision-making, Allison has developed models derived from an incrementalist perspective; and, in this context, Simon's notions of 'bounded rationality' and 'satisficing' are also relevant.\(^{(63)}\) In *Essence of Decision*,\(^{(64)}\) Allison utilises two models: the Organisational Process Model (OPM) and the Governmental Politics Model (GPM). Cornford\(^{(65)}\) and Ball\(^{(66)}\) have queried whether there is any real distinction to be made between the two models, and, indeed, elsewhere\(^{(67)}\) Allison combines the two models into one, the Bureaucratic Politics Model (BPM).\(^{(68)}\)

The BPM views decisions not as the outcome of consensus and harmony but as the outcome of a series of bargaining games. There is no unitary mode of action but rather a pluralistic mode where there is no single strategy for solving a particular problem but many strategies. Organisations are made up of disparate, decentralised units in which the actors perform with different perspectives and priorities, and decisions are made by much pulling and hauling among them, and not by a single rational choice as in the RAM. The BPM is also concerned with how certain patterns of activity take place in an organisation, focusing on the pattern of statements, directives, and actions of the relevant departments and parts of an organisation including the adoption of bargaining strategies, tactics, conventions (rules of the game), routines, SOPs, and so on.

Dimmock and Barnard's\(^{(69)}\) pluralist view of organisations (in their case the NHS) shares a similar focus on the per-
pectives of individual actors in any decision process.

The pluralist view sees organisations as containing a number of related but separate interests and objectives which must be maintained in some kind of equilibrium. Instead of the concept of a corporate unity reflected in one source of authority and loyalty, there exist rival sources of leadership and attachment.

The authors acknowledge the fact that 'to date the health field has neither admitted nor subscribed to analyses of organisational behaviour which point to the existence of conflicts of interest and the pursuit of sectional interests'. (70)

Incrementalism perceives decision-making as a political activity, where proposals and decisions are to the advantage of some but inevitably, too, to the disadvantage of others. It also acknowledges the importance of institutional structures, like the NHS, within which decision-making is undertaken. These are characterised by divisions of tasks faced by an organisation into separate predefined parts; duties are allocated to different positions. The rational, or unitary, model assumes that these separate divisions interlock efficiently, as in Weber's view of bureaucracy with its division of labour and hierarchical nature, in order that a comprehensive and coherent range of instruments can be developed to realise given aims. But an incrementalist, or pluralist, model views these organisational divisions somewhat differently. The notion of 'divisions' refers to political and/or organisational differences, where actors have conflicting loyalties rather than share an overriding loyalty to the organisation as a
whole. It has been suggested\(^{(71)}\) that the major failures of comprehensive planning stem from its definition of comprehensiveness in a world that lacks any comprehensive political power or institutions.

The theory of incremental decision-making is often put forward as an explanation of budgetary processes.\(^{(72)}\) Indeed, Ball\(^{(73)}\) and Allison\(^{(74)}\) argue that budgets and procurement decisions are likely to be more amenable than other types to explanation in terms of bureaucratic politics. In his classic study of budgetary processes, Wildavsky\(^{(75)}\) set out to construct a theory of the formation of the Federal budget based on a detailed description of the decision process surrounding the budget. While emphasising the complexity of the budget-maker's problem, Wildavsky describes a series of 'aids to calculation' to help decision-makers simplify a problem and reach a decision.\(^{(76)}\) Wildavsky's theory is consistent with Lindblom's: emphasis is placed upon the limited capacity of individuals to comprehend the full complexities of their environment. Because of the impossibility of exploring all available alternatives, and the consequent risk of information overload, reality has to be simplified to enable a decision-maker to realise a choice. In short, there are cognitive limits on rationality and, as March and Simon\(^{(77)}\) argue, the rationality of classical 'economic man' (who makes 'optimal' choices in a clearly defined environment) gives way to the rationality of 'administrative man' (who satisfices in place of discovering and selecting optimal alternatives).
Greenwood et al. (78) are critical of explanations of budgetary processes that emphasise 'bounded rationality' and 'satisficing'. They accept that these notions of incrementalism contain a great deal of plausibility, and agree that probably all budgetary processes are incremental in that most of the budget goes unexamined in any single year. The two health boards chosen for the present study proved to be no exception, as later chapters show. The authors also accept that one of the reasons for the lack of a comprehensive review is probably the limited information handling capabilities, and finite intellectual abilities, of decision-makers. But the weakness, in their view, of this limited rationality thesis ... is its inability to explain why some budgetary processes are more or less incremental than other budgetary processes. The implication is that incrementalism could be avoided, or reduced, by increasing the intellectual capacity of budgetary actors, or by reducing the complexity of the information at his disposal (eg by using a computer). (79) (emphasis added).

Cornford (80) shares some of these misgivings, claiming that 'there is much in government which is not incremental and much that may be incremental in appearance though not in consequences'. Furthermore, he maintains that disjointed incrementalism ... exaggerates the degree of stability and regularity in government; (81) (emphasis added), a view also held by Ruggie (82) who believes that incrementalism oversimplifies social complexity and decision-making processes through its sequential ordering of events and procedures and their individual marginal adjustment. In other words,
incrementalism may carry with it the danger of imputing to decision-making a degree of rationality which is, in fact, not present.

Greenwood et al propose an adapted incrementalist model which incorporates some of the inchoateness of political processes which can operate at random, often according to the dictates of fashion. The authors maintain that because

budgets are the outcome of clashes between entrenched interests ... a more adequate theory of budgeting .... will have to be based upon the political features of organisational life, rather than upon the cognitive deficiencies of decision actors. (83)

The authors are critical of Wildavsky's approach because although he is aware of 'the politics of organisational life', his explanation of the budgetary process fails to capture this dimension. Only by examining organisational politics (synonymous with the notion of administrative politics) is it possible to account for why some budgetary processes are more incremental than others. To meet their objective, Greenwood et al present a set of concepts designed to capture organisational politics. The concepts refer to a number of the dimensions which form the frame of reference cited at the start of this chapter, and are concerned with the impact of the environment on decision processes, organisational characteristics and arrangements, and the interests, values and power of those groups which comprise organisations. The authors' concern with intra-organisational values, interests and power is germane to the aims of the case study presented in Part 3. In
Chapters 7 to 9, for instance, these concepts are discussed from the perspective of each of the three groups comprising the policy triad, before the development fund allocation process and the interplay of these three groups and their component parts are described. From the case study of decision-making, it would appear that the scope for change is a product of the very political process within organisations that Greenwood et al are at pains to open up. For instance, earlier chapters have noted the intention within parts of the NHS to shift priority from acute services to non-acute ones. Of this policy initiative, one health board Secretary has written,

the current emphasis on the non-acute aspects of health care may be the correct one but it is difficult to avoid the conclusion that it owes more to political judgement - if not hunch - than to any objective assessment of needs and resources.

Greenwood et al, as Judge points out, have not discarded the concept of incrementalism but have added substantially to it in an attempt to overcome some of the criticisms levelled at it, in particular its tendency to oversimplify reality, that is, to make it appear more ordered than it usually is, and its tendency to reduce problems to ones of technique rather than of politics. Nevertheless, Judge is not wholly persuaded by the authors' analysis and attempt at revisionism, and suggests that perhaps Greenwood et al 'exaggerate the occurrence of overt conflict between sub-units for resources', paying insufficient attention to the fact that 'organisational procedures minimise opportunities for open conflict'. (emphasis
added). Routines and SOPs are a key element in Allison's BPM and they also feature in Danziger's study of local authority budgeting in England. While clashes between entrenched interests need not always actually occur, it is important to appreciate that mere anticipation of them may be sufficient for decision-makers to attempt to avoid or minimise them. This line of argument refers back to Lukes' three-dimensional view of power and his concept of latent conflict 'which consists in a contradiction between the interests of those exercising power and the real interests of those they exclude'\(^{(88)}\). Moreover, recalling the earlier discussion of the presence of puzzlement in social policy-making, it is important not to overlook this neglected, albeit intangible, factor. Its influence may be unrelated either to overt, or to latent, conflict but may result in incremental decision-making all the same. Cornford expresses appositely the very real paradox that exists between the operation of routines in a decision process, and the degree of uncertainty and puzzlement that is present. Although his remarks are directed at governmental decision-making, they are equally applicable to the NHS.

We may have to accept that any modern government is an incoherent system. A system because, while there is muddle, the pattern of its activities is not random; most of the conditions and constraints within which it operates have some stability over time; and there is also a degree of stability in the behaviour of its component parts. Incoherent both because there is muddle and because the pattern of events is in fact and in principle unpredictable by participants. The complexity of events is too great for them to grasp what is going on and they do not know how they themselves are going to act. If ... we mean anything by decision-making other than the illusion of choice, it must
involve some element of chance. (90) (emphasis added).

4.4 The Application of Theory to the Case Study

Klein (91) has noted that different modes of explanation have variable explanatory power, depending on the issues involved. From the foregoing discussion of rationality and incrementalism as aids in understanding decision processes, it can be concluded that it is necessary to adopt both perspectives if a more complete picture is to emerge which is able to account satisfactorily for many, if not all, of the practices observed in the two health boards. The RAM, as it has been defined, is limited since, as Dror (92) claims, it ignores extra-rational processes. The existence of these requires no elaboration. If rationality prevailed, then the NHS would not suffer from the gross resource imbalances between regions and between specialties (both within and between regions) which do exist despite successive attempts to remove them. (93) Chapter 2 commented on Scotland’s advantageous position in terms of per capita expenditure on health, and while a rational explanation of this is conceivable (i.e. Scotland’s poor health record), the real reasons probably lie in the realm of political and administrative practices as Godber alleges. Moreover, if further confirmation were needed of the existence of a low degree of rationality in resource-allocation, is not the existence of RAWP, and, to a lesser extent, SHARE in Scotland, testimony to the fact that gross imbalances stemming from historical precedent persist?
The overview of the NHS presented in Chapter 1 described a fragmented decision-making environment with many competing interests, as opposed to a unified, comprehensive one. Furthermore, Klein's analysis of macro-decision-making in the NHS is indicative of a low degree of rationality.\(^{(94)}\)

And yet, as has already been noted, adherence to a rational paradigm (through an emphasis on management skills and techniques) played a central role in the design of the structure which emerged in 1974. Therefore, the decision-making environment in the two health boards, certainly from a structural standpoint, largely reflected the concerns of a rational model (for example, the emphasis on role clarity and precision; and the commitment to 'delegation downwards' matched with 'accountability upwards').\(^{(95)}\)

For these reasons, the notion of rationality, as conveyed in the preceding section, cannot be dismissed as being of no value in an attempt to penetrate and to understand particular decision processes. Moreover, there exist multiple perceptions of rationality in the NHS. For example, doctors share a concept of rationality that appertains to standards of care for individual patients, whereas administrators view rationality as linked to equity of service provision and the most economic use of resources.\(^{(96)}\)

For different levels of organisation (eg areas and districts) it may also be rational for those administering them to argue for the best possible levels of service provision, even if by doing so the attempt to equalise service provision throughout the area may be made that much harder to
achieve. This notion of rationality was a feature of the two health boards observed, and it influenced attempts by the areas to achieve savings.\(^{(97)}\)

It is necessary to point out that a more rational budgetary review process, by which is meant the formulation of clear policy statements of objectives which are related to expenditure proposals, will not necessarily produce less incremental decisions.\(^{(98)}\) To some extent agencies have adopted management techniques to create an impression of efficiency and rationality, but whether the techniques have been fully implemented remains doubtful. Danziger provides evidence to support his contention that the use of management techniques 'is rather more image than substance,' with techniques like PPB having been instituted 'without ever being actually implemented in a meaningful fashion'.\(^{(99)}\) A more subtle explanation of the failure of management techniques to introduce rationality into decision-making is, according to Danziger, the fact that 'perhaps ... management techniques actually do tend to produce more incremental budgetary decisions ....' It is possible that 'rationalising' the budgetary process alters the decision structure in a manner that makes reallocation less likely'.\(^{(100)}\) By increasing the visibility of a decision process and by allowing many more individuals and groups access to it, it is possible that this 'array of factors might increase the possibility of conflict among budgetary actors'.\(^{(101)}\) Strategies are then deployed to avoid or minimise conflict. Danziger found, in his study
of four English county boroughs, 'that the more "rationalised" budgetary process generated more rather than less incremental decisions'. (102) In their study of public spending in Britain, Heclo and Wildavsky (103) reached a similar conclusion.

It should be emphasised that Danziger's observation that management techniques can lead to greater, rather than less, incrementalism does not invalidate the point being made here about an ideal-type model of rationality. The fact that employment of such a model may have unintended, or even intended, consequences is not relevant. What Danziger's argument clearly shows is that mere instrumental devices alone cannot alter the behaviour of the decision-making environment as much as the environment can distort the operation of these devices. (104) Unless a consensus over priorities, objectives, and so on can be reached then it is unlikely that management techniques can achieve much by way of innovative shifts in policy. Although these techniques are a by-product of a RAM, unless, as Allison puts it, there is also a 'single, coherent, consistent' (105) view about particular problems and how they might be tackled, then the techniques are of little value in themselves.

As for incrementalism, it has no place in a situation where the past is of no importance, where decision-makers all act as one united group with no bargaining or compromises to be forged, or where politics has no place in the decision-making process (in other words, where a RAM is applicable). The
NHS, as this and preceding chapters have shown, and as subsequent chapters will show further, is not such an environment. Therefore, in addition to the adoption of a conceptual lens based on multiple notions of rationality through which to view the NHS, it is necessary to adopt a conceptual lens based on notions of incrementalism. This dual perspective directs attention to the shape of the organisational structure in the decision process observed, to the organisational procedures and routines in operation, and to the interplay between the various participants in the process. The frame of reference outlined at the start of this chapter is flexible so as to allow this dual perspective to be employed - each particular perspective leads a researcher to raise, and seek answers to, particular types of questions. In the present research, there are no hypotheses to be tested (see further below), only a loose structuring of the environment through the deployment of the frame of reference, fleshed out with rational and incrementalist theories. Conceptual frameworks structure the complex universe for the analyst; they determine the level of detail and limit the range of consideration. They also enable certain questions to be posed, and asking the right questions is an essential prerequisite to obtaining the correct, or at any rate, meaningful, answers.

Limitations of Theories/Models

The usefulness of theories and models can lead to exaggerations of their potential. Because of limitations inherent in their nature, they need to be employed with caution.
This is especially so in the case of models, and in his analysis of Allison's models, Cornford claims that in each case the simplification necessary to understand complex phenomena distorts our conception of the reassembled whole. In the one case, (ie the RAM) collective values, intentions and motives are exaggerated, in the other (ie BPM) their reality is denied, and both overestimate the consistency, the regularities, of the world they describe. If one imagines the governmental process as lying somewhere between a battle and a game of chess, these models begin and end too near to the orderly ..., rule bound, and reflective world of chess. (107) Although true even of incremental models, as the previous section attempted to show, it is possible to adapt incrementalism to enable the irregularities (ie the muddle, the complexity and the unpredictability) of actual decision processes to be captured. Notwithstanding these efforts at revisionism, whether incrementalist theories fully portray the complexities of decision-making is questionable. As was pointed out, a major flaw is the linearity implicit in this class of theories which assumes a sequential progression of decisions aimed at solving particular problems marginally but with a sense of direction. In the real world there is more confusion and uncertainty than is allowed for even by incrementalism. Identifying a particular model, or class of theories, with reality can, therefore, lead to over-simplified conclusions that may be incorrect or, at any rate, incomplete in the sense of conveying the subtle nuances present in what is being described. In contrast to the complexity of decision-making, models
and theories are simple and one-dimensional. Dror\(^{(108)}\) argues that decision-making is not necessarily deterministic, which is the implicit assumption certainly of rationality and perhaps of incrementalism too; it is partly probabilistic and partly arbitrary.

Basically, what is being proposed here is the desirability of a more flexible use of competing models or paradigms. Through the adoption of a mixed approach (ie combining insights derived from rational and incrementalist perspectives, as well as from notions of puzzlement and uncertainty) it might be possible to gain more meaningful insights into decision-making from a multi-dimensional perspective rather than from a unitary, and hence rather blinkered, perspective. This means departing from the rigours of positivism with its strict rules governing the theoretical underpinnings of research.

**An Alternative Approach**

The approach being advocated here resembles the multi-paradigmatic approach to social science research favoured by Rein\(^{(109)}\) which may be distinguished from the positivist perspective which tries, basically, to establish general laws which remain stable through time. Rein is critical of attempts by positivists to separate facts and values in their endeavour to apply methods of social inquiry that would be more appropriate in the natural sciences. Schatzman and Strauss\(^{(110)}\) are also critical of the positivist tradition in social research which, they
allege, has led to an over-emphasis on quantification and measurement. They maintain that since the 1920s there has been systematic discrediting of man's ability to make valid observations and inferences of his own. Carrier and Kendall\(^{111}\) share this view and believe that the positivist approach fails to take adequate account of the nature of social phenomena primarily because it tends to disregard the point that societies, and the organisations within them, are human products. Hence positivism fails to generate adequate accounts of the development of social policy. Carrier and Kendall's alternative approach is based on a phenomenological perspective.\(^{112}\) In its application to the development of social policy, which is Carrier and Kendall's main interest, explanations derived from this perspective should be sought in terms of members' 'knowledge of society and its social problems'. Recognition is then given to the 'different frames of reference, different perspectives of reality ... different versions of the issues at stake' which are involved in the policy-making process.\(^{113}\)

In an attempt to understand the decision process selected for the case study, an emphasis has been placed on the participants' explanations of why things happened as they did. This is not to assert that an adequate account of the process will emerge from the disparate accounts of different participants in that process, but rather to reaffirm the view that studies which aim to discover why participants acted in particular ways may best be achieved by focusing on the actions, or inactions, of these actors. Valuable insights may be obtained in this way, complement-
ary, rather than superior, to those insights that will emerge from other forms of social inquiry.

If the present research were to have been conducted in accordance with procedures associated with positivism, it would have been necessary to construct hypotheses firmly rooted in some theory, to test these empirically through the employment of rigorous methodological techniques, and then to isolate a generalised law, or laws, based on an analysis of the data, which would either support, or refute, the hypotheses. However, as has been argued in the review of decision-making theories, elements of all of the theories probably have some bearing on decision-making. For instance, although there appears to be great value in the insights into decision-making processes provided by incrementalism, the theory is unable to account satisfactorily for an actor's, or actors', adherence to rationality, even if this adherence serves only as a public guise for activities which, when judged by the criteria of what constitutes rationality, may be considered 'irrational'. In other words, it would be a mistake, and would be simplifying reality, to jettison all notions of rationality since they perform, at the very least, a legitimatory function for decisions that are finally reached. As was argued earlier, it is an important part of the public image presented by organisations that decisions are put across as having been rationally arrived at. Furthermore, the multiple perceptions of rationality which exist cannot be ignored, although these may have little to do with the
notion of 'rationality' as defined by rational theory. Likewise, a rigid attachment to incrementalism is more than likely to inhibit a researcher from considering the dimension of rationality which is clearly of some importance in accounting for the actions of decision-makers, even if the actual outputs of the decision process may give cause for doubt.

Moreover, incrementalism can be interpreted in different ways. Earlier sections of this chapter showed that one interpretation stresses the cognitive deficiencies of decision-makers and the technical problems arising from poor, or non-existent, information, while another interpretation stresses the political and organisational dimensions inherent in decision processes where conflict and clashes of interests are emphasised. While accepting that elements of both these perspectives are valuable, it is felt that other dimensions that have been omitted by these interpretations of incrementalism should be incorporated in any examination of decision-making. For instance, as was argued, political and organisational dynamics are not just about conflict; they are also about routines and SOPs. Moreover, decision-making can also be about puzzlement rather than about power and even if about power, this need not always be a straightforward overt A has power over B type configuration, but may operate in a more subtle fashion. The overriding concern, then, is to assimilate these competing approaches in such a way that an understanding of a particular process can emerge which captures as much as
possible of what happened.

Klein's observation that different modes of explanation have variable explanatory power has already been mentioned, although it is worth expanding on his ideas. He suggests that 'to talk about theories in the plural presupposes that different modes of explanation are not necessarily mutually exclusive, and that their explanatory power may vary with the situation to which they are applied'.\(^{(114)}\) Although there appears to be some convergence between Klein and Rein on the use of theories or models in social research, Klein seems to be saying that different issues require different modes of explanation rather than that different modes of explanation may be used to explore a particular issue. Rein, on the other hand, seems to be closer to the latter position. He argues that 'the broader competing frameworks of disciplines, and of methods, and of values, cannot be dismissed ... easily, and this raises the question of what to do when more than one paradigm is important for action.'\(^{(115)}\) Essentially, Rein is concerned with searching for a way of assimilating the insights provided by paradigms, and for him the answer lies in a multi-paradigmatic perspective with which to understand events and to interpret policy. 'Many paradigms contain stories which describe intrinsically good ways of looking at reality ... . These are persuasive whether or not we accept the whole paradigm of thought from which they come.'\(^{(116)}\) Rein likens the process to story-telling, which 'extracts the insights of particular paradigms from the paradigm itself and thus makes possible
This eclectic approach, which forms a middle-way between, on the one hand, a rigid attachment to a particular theory, and, on the other, entering a field with no explicit analytic framework for guidance in data selection and for establishing criteria of what is relevant and what is irrelevant, can be criticised on the grounds of validation problems. Rein concedes that 'the validity of the explanation of what happened - interpreting why the sequences of events occurred - is much harder to assess. The validity of explanations is elusive.'\(^{(118)}\) All that can be asserted is that 'the story should be the simplest, most comprehensive, internally consistent explanation we can offer, and it should also be consistent with possible explanations of similar events.'\(^{(119)}\) The generalisability of the explanation is also important for there is a tendency to reject, or, at any rate, to attach less value to, explanations that focus on the personal qualities of particular actors 'not so much because they contain no truth but because they are unique.'\(^{(120)}\)

Schatzman and Strauss\(^{(121)}\) are also concerned with questions of validity and verification and argue that the central question for the field researcher whose view of social reality is one of infinite complexity (hence the appeal of a multi-paradigmatic perspective) is: would an independent observer make conceptual discoveries that empirically, or logically, invalidate his own? Perceptual and conceptual selectivity must be taken for granted. Either analysis
may be conceptually superior, but if any fails to contradict the original research, then it must be regarded as supplementary or complementary.

4.5 Conclusions
This chapter has been concerned with examining the theoretical considerations which underlie the case study of decision-making, or, to be more specific, a particular decision process, in two health boards. The chapter began by outlining a conceptual frame of reference for studying decision-making, and the discussion proceeded to an investigation of theories to flesh out the skeletal framework. While acknowledging that incrementalist theory best enabled a researcher to describe what was being observed, it was stressed that this theory contained deficiencies. Moreover, since assumptions of organisational rationality had been a prominent feature in the reorganised NHS, then notions of rationality could not be dismissed.

In addition to recognising the particular limitations of particular theories/models, it was accepted that all theories and models suffer from built-in drawbacks. While a priori conceptualisation is indispensable to the selection of data, this can be a handicap if it 'blinds' a researcher, permitting him to pick up only what the conceptual lens identifies as important. Other factors, or stimuli, although equally, perhaps more, significant, may fail to come within his purview as dictated by the theoretical framework.
For these reasons it was felt that a more flexible, 'open' analytical perspective, which relied on a multi-paradigmatic approach, would be more appropriate than a rigid attachment to a particular class of theories, or models, of decision-making. If one is adopting a perspective which attaches importance to 'comprehending the actors' view of reality ... it follows that the attachment of many researchers to a priori definitions and hypotheses must ... be brought into question.'(122) This is not to deny the need for a structuring of the environment under observation, which then allows the researcher to focus upon specific areas of interest. It is the degree of structuring which distinguishes a multi-paradigmatic approach from a more orthodox use of theories/models.

By using different theories, or competing frameworks, loosely, in order to structure the environment to be observed, it is hoped that this will make for a richer, deeper profile of a particular decision process which, in addition, will overcome some of the shortcomings of relying on a particular theory or set of hypotheses. As Klein points out, all 'tools of explanation ... explain something; none explains everything'. An example of the rigidifying properties of theory will suffice to illustrate the advantages of a more flexible, mixed approach. As was noted above, there is a tendency for incrementalist theory to underestimate the confusion and muddle often found in a decision-making process (although to a far lesser degree than a rational model). But are decisions the product of
a stated rationale, or do they perhaps just happen, for reasons to do with puzzlement or uncertainty? This possibility was raised by an NHS administrator at a conference who expressed doubt as to whether decisions were actually being taken or whether particular services were merely 'obtaining' resources.

Rein's concept of story-telling, which draws on insights provided by numerous paradigms and attempts to relate these to events being observed in order better to understand the events, and his value-critical approach to social research make it clear that some kind of theoretical framework is essential as a guide for moving about the field in a reasonably coherent manner. Such a framework is a useful signpost since

information and data can never be understood in isolation from the context of ideas which give them meaning. And it is these frames, or modes, or values, or ideologies, or theories, or whatever we choose to call them, which are crucial for any creative work; for without them, we have no question to ask. Problem-setting is as important as problem-solving because the frames which organise thoughts shape the conclusions we reach. (124)

The theoretical basis of the case study is not aimed at proving, or rejecting, hypotheses; its chief purpose is to provide a frame of reference with which to study and to understand decision-making in a particular setting from the decision-makers' perspective, or perspectives. A theoretical straightjacket would not be appropriate for such an exercise, hence the attraction of an approach that draws freely upon different theories as these appear relevant in a particular instance.
Methodological considerations are an important aspect of any piece of research. However, in field research of a qualitative descriptive nature such considerations are not always given the detailed attention characteristic of a great deal of quantitative, 'scientific' social science research. In qualitative field research, the researcher often performs a more intimate role with those groups and individuals he is observing than is normally the case with research of a rigorous, quantitative type. There is greater flexibility in the researcher's approach, and an empathy between the researcher and those he is observing may be established. There are disadvantages as well as advantages with this strategy. Both have to be weighed against each other to decide whether or not the risks involved are worth taking. For instance, the possibility of biased observations has to be set against the view that an empathic relationship between a researcher and his subject might be conducive to greater openness. Researchers utilising scientific methods tend to be distanced from their data sources. This greater detachment is achieved through the use of highly structured interviews, questionnaires, and so forth. The differences in research styles have given rise to criticisms of the methodology surrounding field research. Strauss et al.\(^{(1)}\) maintain that
there has been little attempt to systematise and rationalise the procedures involved (in conducting field research). Accounts by fieldworkers have tended to be vague about the logic of the operations through which data were gathered, while the techniques utilised for data collection frequently have been left unspecified.

The authors point out how 'fieldwork has been criticised by many social scientists as subjective, unsystematic, and unreliable. These criticisms are not surprising, considering the tardiness of fieldworkers in spelling out their research operations'.

It is essential that the methodology utilised is made as explicit as possible, which is the purpose of this chapter and the next.

Qualitative methods have a number of advantages over other, usually quantitative, analytical methods, although these often go unnoticed. So often advocates of qualitative research are forced on to the defensive by the alleged superiority and rigour of 'hard-nosed' positivism. Quantitative policy analysis has tended to concentrate on inputs and outputs; patterns may be identified but such studies do not show how or why these occur. They tell us very little about what goes on in the 'black box' which is interposed between the input stage and the output stage. Sharkansky has said that some areas of policy-making have so far proved not to be amenable to rigorous measurement. He believes that quantitative policy analysis has three shortcomings: (1) statistical relationships do not provide a thorough explanation of interstate variations in measures of government spending (Sharkansky's study concerned differences in spending among American States); (2) even where
statistical explanations of interstate variations are impressive in magnitude, they do not by themselves provide a satisfactory explanation of human activity that is reflected in numerical relationships; (3) statistical relationships do not illustrate the activities of particular individuals who are identified by perceptive individuals as being critical to certain spending decisions.

Dye, in his study of policy-making in American States, accepts that perhaps the effects of politics on policy outcomes are too subtle to be revealed in quantitative analysis, which is too crude to reveal the real impact of political variables on state activities. Lockard points out that one must never forget that the political process is human, that it depends on notions in men's minds, and that statistical inference must always be made with the utmost caution. By concentrating on quantifiable variables political reality can be overlooked. Lockard concludes by arguing for more in-depth research into how decisions are made. As will be suggested below, the case study approach is perhaps best suited to such a task. First, however, it is necessary to dispose of some of the criticisms levelled at case studies.

5.1 Disadvantages

Stein defines a public administration case study as

a narrative of the events that constitute or lead to a decision or group of related decisions by a public administrator or group of public administrators. Some account is given of the personal, legal, institutional, political, economic and other factors that surrounded the process of
decision, but there is no attempt to assert absolute causal relationships ... Emphasis throughout (the case study) is on decision, whether taken as act or process ....

Hall et al claim that while 'the use of case studies has proved an attractive way of illustrating and conveying the rich detail of various kinds of events', as a research method their 'status remains somewhat dubious'. Two main criticisms are made of case studies: (1) the approach has not been employed in a sufficiently scientific way to advance theory; (2) the case study does not lend itself to generalisation however carefully used. Critics coming into the former category seek improvements in what they regard as a potentially valuable means of developing middle-range theory (the approach adopted here), whereas those in the latter category do not regard case studies as capable of doing more than describing and illustrating. Hall et al refer to these two groups of critics as 'optimists' and 'pessimists' respectively.

As was pointed out in the last chapter, the theoretical weaknesses of case studies have concerned Heclo who believes that 'behind these many efforts has been the implicit premise, or hope, that once a certain critical mass of descriptive studies had been reached theory would almost automatically break through'. But this has not happened, and, at most, claims Heclo, case studies 'have generally been able to conclude with certain moralizing themes....' The majority of studies have taken the form of 'isolated, episodic descriptions .... which are apparently thought to be of intrinsic interest', despite there being 'nothing
about the case study technique which is inherently non-theoretical ... \(^{(11)}\)

At an operational level, case studies encounter more mechanical difficulties. These include inaccessible data resources, and the danger in an in-depth study of identifying with participants (see above). Assuming a satisfactory resolution of these problems, there is then the need to establish validity for the results of the case study - a problem referred to in the last chapter. 'The task of generalising from the particular is especially severe...\(^{(12)}\) and is reinforced by the possibility that (1) the case may incompletely perceive its object of study, and (2) its object of study may misrepresent the universe to which it has reference.\(^{(13)}\)

Among the pessimists, there is also concern at the analytical shortcomings of the case study method. A major weakness is its inability to provide convincing confirmation of hypotheses. Although case studies may describe the multiplicity of factors involved in decision-making processes, they offer no means of dealing with them analytically. 'Questions about the interdependence, overlap, weighting or relevance of variables are, it is argued, not taken into account ...' \(^{(14)}\) In contrast, statistical methods are equipped to deal with such research problems.

5.2 Advantages

Hall et al put forward three arguments in favour of the
case study method:

(1) The method is as effective as other approaches in suggesting general propositions about how policy develops. Because such propositions emerge from the close examination of actual examples, they are likely to prompt good middle-range theorising.

(2) The case study is a valuable means of conveying the immensity of the task confronting those who embark on the journey from description to generalisation.

(3) At a time when the strengths and weaknesses of positivist social research are undergoing critical examination, some of the advantages of the case study may be better appreciated. It is suited to the exploration of the meanings actors attach to their behaviour in decision-making situations. (15)

The authors emphasise that for the case study method to make a truly valid contribution, it must be employed in a disciplined way. Several safeguards are necessary, two of which are particularly relevant in the present context. First, there is the need for a conceptual framework, however modest or rudimentary, with reference to which the cases are studied and conclusions drawn. There must be a set of questions which the cases are intended to help answer. This provides a delimiting context. Marmor(16) also emphasises the importance of a framework since case studies inevitably mix the peculiar and typical, general and specific, thematic and descriptive. The last chapter outlined a suitable frame of reference for the case study presented in Part 3. Second, as Hall et al(17) are aware, case studies of policy-making overwhelmingly move towards a conclusion - a point of decision. Yet policy formation is clearly a flow of events and actions over time in which few of the participants will be concerned with that development alone ... . The researcher raises
it to a special position and thereby artificially removes it from the press of other concurrent, overlapping and competing events.

A similar point is made by Donnison et al\(^{(18)}\) who argue that accounts of administrative processes often make them appear 'deceptively systematic and continuous'. The authors acknowledge that the completion of a task, or the progress of a development, seldom fully occupies the time of those responsible for these matters. The decision process, or development, in which one has an interest

More typically consists of one item towards the end of a crowded committee agenda, a telephone call made the following month, a paragraph in a memorandum prepared over the weekend dealing mainly with other matters, then a hurried departmental meeting followed by a chance conversation between two people on their way to lunch. Such are the scattered incidents - if the researcher is fortunate enough to trace them - which should be threaded together to produce what the participants may later regard as an unrecognisably coherent story. \(^{(19)}\)

The present account of the allocation of development funds in two health boards is susceptible to this danger and a sense of perspective is necessary in order to avoid this from happening. One of the aims of Chapters 7 to 9, which describe the decision actors who comprise the policy triad and the organisational structures they occupy, is to locate the development fund allocation process within a broader perspective.

Heclo\(^{(20)}\) suggests two further advantages of case studies: first, the ability of case studies to 'move' with the reality of dynamic factors. Their focus on social relations among individuals and groups in natural settings provide data of great importance for the study of organisa-
tions. Case studies are ideal for identifying the 'moving parts' of an organisation and for concentrating on how things work. As Kaufman\(^{(21)}\) notes, they point up the intricate process of negotiation, mutual accommodation, and reconciliation of competing values from which policy decisions emerge. They throw into prominence the strategies and tactics of people involved, displaying techniques of coalition, delay, and manipulation of formal rules in pursuit of personal and organisational objectives.

Heclo's second advantage is that with case studies a variety of data-gathering methods can be used, including direct observation, interviewing, and documentary analysis. Eckstein\(^{(23)}\) does not rule out the possibility of generalisations emerging from case studies, but believes that they (ie case studies) 'never "prove" anything'. Their purpose is to illustrate generalisations which are established otherwise, or to direct attention towards such generalisations. By focusing on one area of decision-making in two places at more or less the same points in time (two health boards), it is not possible, as Eckstein says, to 'prove' generalisations. However, there are ways of coping with this problem. One method is to obtain multiple observations over a lengthy period of the same phenomena. Reliability is ascertained through the stability of the processes observed (ie it is possible to discover whether or not the organisational features and decision-making practices are variable). A second method is to supplement the in-depth case study with checks on the processes undertaken by other similar organisations in similar fields of decision-making. The next chapter describes the
methods adopted to achieve this.

If there is a limit on how convincing (and valid and reliable) generalisations drawn from one case study can be, then it is useful to recognise, as Chapman(24) does, that every problem and every decision in public administration is peculiar with no one, obvious, accepted 'administrative process' to which all specific cases conform. However, even after allowing for these limitations, case studies can still be of value in contributing further to knowledge of certain processes, particularly when little is known about these. It was pointed out in Chapter 1 that one of the principal aims of the present case study was to add a measure of understanding of the administration of the NHS, particularly at a local level.

It is perhaps worth concluding by noting that there are many issues and problems which neither the case study nor statistical methods can resolve satisfactorily. Objections can be raised to any method of unravelling and understanding complex decision-making processes. 'There is ... the more extreme view that political phenomena as such are not amenable to scientific study and that we must rest content, therefore, with conclusions of an entirely speculative and impressionistic kind'.(25)

One need not go so far as to subscribe to this view in order to agree with Kaufman(26) who suggests that case studies compel caution in the application of the 'principles' of administration to life situations. They reveal administra-
dilemmas of conflicting loyalties besetting almost all who participate in large-scale organisations. 'Cases warn us to view suspiciously all sweeping generalisations about administrative behaviour, to avoid the uncritical idealisation and automatic denunciation of participants in the governmental process'. They alert a researcher to the danger of oversimplification and make him conscious of the fact that every proposal for any kind of change deprives someone of something he is accustomed to or would like to have, and that routine actions often embody sweeping changes from somebody's point of view. Kaufman(27) concludes: 'each addition to the storehouse of cases is a welcome - a needed - enrichment of the study of public administration'.
Chapter 6

RESEARCH METHOD

The research problem and the kinds of issues to be explored having been established, and the reasons for adopting a case study approach having been given, it remains to consider the events surrounding the setting up of the case study and the methods used to obtain data.

6.1 Field Entry

In formulating a research strategy two specific problems became immediately apparent: (1) the need to find 'suitable' health boards,\(^1\) ie in terms of proximity to the researcher's base, size, and complexity; (2) the need to locate an area of budgetary decision-making which was reasonably typical of the sorts of processes with which health boards are concerned, and which would be possible to follow through from start to finish, ie up to, but not including, implementation.

The two health boards chosen (hereafter referred to as Alpha and Beta to preserve the anonymity of officers, members and other personnel) seemed suitable for three particular reasons: (1) they were both within easy reach from the researcher's base; (2) they were both medium-sized boards (in terms of population and in terms of resource allocations) and were reasonably representative of the sorts of problems, pressures, and constraints facing all fifteen health boards in Scotland. The boards selected both had a mixture of urban-industrial and rural areas; (3) the size
and structure of the two boards were such that one researcher could cope with their intricacies. Both boards were divided into two districts (ten of the fifteen health boards are divided into districts for administrative purposes). Diagram 4 shows, in simplified form, the organisational structure of the Scottish NHS listing the principal decision-makers involved in the decision process observed.

Each of the fifteen boards has its own peculiar characteristics, not just those arising from the personalities of members and officers but those resulting from the facilities provided, and the type of hospitals maintained (in all these respects Alpha and Beta differed, although they were similar in other ways as noted above). It is not possible, therefore, to pinpoint a typical health board. This caveat apart, it is hoped that there is some validity in the selection of these particular health boards. As the three criteria listed above indicate, the selection was not entirely arbitrary. It was partly in an attempt to overcome some of the more extreme peculiarities of certain health boards, eg the island authorities (Western Isles, Orkney, Shetland), or the Highland board, all of which have special problems to deal with which are not found elsewhere, that the case study confined its search for appropriate boards to those with what might be loosely termed average characteristics, ie in terms of population size and funding (see Table 6.1), and which were situated in the mainstream of health problems facing all boards but
**NOTES:**

1. There are no advisory committees at district level in Alpha. They are present in Beta.
2. The DEG has a line management relationship to the AEG; sectors are accountable to districts (indicated by arrows in diagram).
3. Local Health Councils tend to operate at district level but they are set up by the area.
### TABLE 6.1 Health Boards: Approximate Population and Revenue Allocations 1975/76

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Approximate Population</th>
<th>Final Revenue Allocations* (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll and Clyde</td>
<td>460,200</td>
<td>29,880,000</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>374,400</td>
<td>17,492,000</td>
</tr>
<tr>
<td>Borders</td>
<td>99,100</td>
<td>5,834,000</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>143,700</td>
<td>10,536,000</td>
</tr>
<tr>
<td>Fife</td>
<td>337,700</td>
<td>19,124,000</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>267,000</td>
<td>18,909,000</td>
</tr>
<tr>
<td>Grampian</td>
<td>447,900</td>
<td>35,644,000</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>1,129,400</td>
<td>118,924,000</td>
</tr>
<tr>
<td>Highland</td>
<td>178,300</td>
<td>15,659,000</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>563,100</td>
<td>30,398,000</td>
</tr>
<tr>
<td>Lothian</td>
<td>758,400</td>
<td>69,433,000</td>
</tr>
<tr>
<td>Orkney</td>
<td>17,500</td>
<td>923,000</td>
</tr>
<tr>
<td>Shetland</td>
<td>18,400</td>
<td>1,131,000</td>
</tr>
<tr>
<td>Tayside</td>
<td>401,200</td>
<td>43,852,000</td>
</tr>
<tr>
<td>Western Isles</td>
<td>30,100</td>
<td>1,704,000</td>
</tr>
</tbody>
</table>

*Allocations to Health Boards on revenue account for Hospital Services and Community Health Services in the financial year 1975/76.

**Sources:** Factsheet, The National Health Service in Scotland, Scottish Information Office, 1976, p.3; Scottish Office Finance Division.
especially those in lowland Scotland where population and health care needs are concentrated.

Although seemingly a rather trivial detail, travelling distance was an important consideration, particularly when meetings were, on occasion, held unexpectedly at short notice. Other meetings were convened on consecutive days which involved more intensive travelling. It was essential, therefore, to locate boards which were easily accessible. It is worth noting in this connection that when one is working alone on a research project of this nature the sheer mechanics of organising field work assume greater significance than is perhaps the case where a team of researchers is engaged on a project. If one is investigating similar decision processes in two similar institutions over the same period, then one has to avoid possible timetable clashes where meetings can coincide. It is much easier for a research team to overcome such logistical problems than it is for a lone researcher. This was the chief reason for not undertaking field work in both Alpha and Beta simultaneously (see further below).

Satisfied that Alpha and Beta fulfilled certain requirements, the next step was to contact the Secretary of each board by letter informing each of them of the outline of the proposed research (very general at this stage) and requesting their assistance and that of other officers. Since efforts were concentrated solely on Alpha during the first year of the research project (Beta was not contacted, and observation did not commence there, until the second
the following remarks refer specifically to Alpha since the case study was initiated in this board.

In response to the letter, a meeting was arranged with the Secretary of Alpha and the Chief Administrative Medical Officer (CAMO) to explore the possibilities of defining a suitable area of financial decision-making for observation. The only firm criteria laid down for the research project were: (1) that the decision process should be fairly typical of health board decision-making in general (as opposed to a crisis, 'one-off' decision process); (2) that the decision process should have policy implications affecting the provision of services (as opposed to routine, low-level, technical decisions); and (3) that the decision process should have, if at all possible, a clear point of entry and point of exit in order to comply with the time-scale of the research.

The area finally selected for study was the allocation of development funds (DF). These funds represent the only 'new' money which a health board receives annually from the SHHD. Since Alpha was planning to begin examining its requests for developments for the next financial year in January (initial contact was made with Alpha in December), this fitted in with the timetable set for the research.

The allocation of DF appeared to be an ideal area to study for the following reasons:

The decision area was well-defined, was reasonably self-contained, and did not spill over into other decision areas; it had a clear point of entry and a definite cut-off point when decisions on allocations had been taken.
The funds represented the main (in practice often the only) source of 'new' money received by health boards, and were important if changes were desired, or if deficiencies within the Service required attention. In a growth-oriented Service where traditionally expansion has been the norm (or was until the events of the last few years) DF were eagerly relied upon for funding new schemes, or relieving pressure points within existing services.

The allocation of DF involved the principal parts of the organisational structure of health boards, since the two tiers (ie area and districts) and the main participants within each all required to be consulted about proposed allocation decisions.

Finally, the allocation of DF was not a unique once-and-for-all operation. It was a procedure embarked on by all health boards annually. DF were important to all boards because these funds were responsible, in large part, for the kind of service provided to patients. It is hoped that a study of the allocation process may afford a realistic and representative picture of important local developments in health service administration - developments more important than the reorganisation of medical records, for instance, but more local than a change in central government policy.

Before entering the field to observe the process of allocating DF, a statement of research intentions was prepared (3). This briefly set out some background about the researcher, the study objectives, method of work, and gave an assurance of confidentiality for all information gathered. Copies of this were circulated to members of the Area Executive Group (AEG) and, later, to the District Executive Groups (DEGs), Advisory Committees, and the Chairman and members of the board (ie Alpha). Essentially the same process was repeated when observations commenced in Beta.

It is worth emphasising that the area of decision-making finally selected for scrutiny (ie the allocation of DF) owed much to the efforts of the two chief officers in Alpha.
at the first meeting. They suggested that this would be a suitable area to examine. For a researcher, there are both advantages and disadvantages with such an arrangement. In this particular instance, there was a danger that the officers, unbeknown to the researcher, were directing the study into an area which was not going to reveal too much, and which consequently would not expose their working patterns or cause any embarrassment to those involved in decision-making. Moreover, since these officers were advising on what area of decision-making would be appropriate for in-depth scrutiny, the possibility clearly existed that they might be in a position to exercise too much control over the research. But the arrangement also had positive features. First, chief officers (two of them) were closely involved from the start - their assistance and advice (within limits) were sought. There was no reason for them to feel that they were being used for some mysterious project which might be harmful to them. From the beginning it was clear what was wanted from them. Second, by seeking their advice and expertise on the activities of the health board it was possible to select an area of decision-making which was meaningful to the officers and other participants, rather than selecting a decision process based on a perusal of the literature in isolation from the life situation. The decision area chosen for the case study emerged from an interactive process between the researcher and two chief officers. Their cooperation was essential in any case for the success of the study. Therefore, it seemed appropriate to seek their assistance and
approval by involving them in the selection process. That way cooperation was assured, and possible suspicion allayed.

While the allocation of DF may be regarded as the best example of a perennial and recurring issue affecting all health boards in similar ways, it must be admitted that reorganisation of the NHS in 1974 shortly before the case study was set up presented difficulties which were beyond the control of the researcher. Owing to its administrative upheaval, the NHS was in a state of flux, particularly during the early stages of the data-gathering process. This had advantages as well as some obvious disadvantages. On the positive side, the decision-making environment was fluid, positions had not hardened, lines had not been drawn, and various individuals were not yet well entrenched in their new posts. There was a considerable degree of openness throughout the system. Officers and board members were indulging in much self-questioning of their new roles and functions. Up to a point, such an environment can be useful to a researcher who wishes to tap what is happening, because opinions and attitudes which might normally be deeply buried beneath organisational practices and routines are quite visible on the surface.

Nevertheless, there were some disadvantages precisely because the new structure had not settled down. The environment was perhaps somewhat artificial. For example, there tended to be an over-emphasis on certain problems like staffing numbers, job specifications, management structures,
and so on at the expense of, for example, consideration of policy options, priorities, and resource-allocation decisions which had to be taken. One assumes that these diversionary structural matters are temporary. However, since it has been estimated that it will take from between ten and twenty years for the new NHS to settle down completely, it can be argued that a start should be made before then to discover how decisions are being taken within the framework set down in the reorganisation. This has been the view of the Royal Commission on the NHS. However unsatisfactory such a state of affairs may be, one can seek solace in the knowledge that a great deal of social science research is conducted in imperfect environments. As long as a researcher is aware of these imperfections then the end result is a more convincing and honest, if occasionally defective, piece of research.

Quite apart from the reservations noted above relating specifically to the reorganised NHS, all decision-making studies, unless they are conducted in a laboratory (which raises other problems), suffer from one over-riding obstacle, that is, the near impossibility of being able to obtain all the multifarious elements which comprise any decision process in a complex organisation. In his classic work, Barnard noted:

Not the least of the difficulties of appraising the executive functions or the relative merits of executives lies in the fact that there is little direct opportunity to observe the essential operations of decision. It is a perplexing fact that most executive decisions produce no direct evidence of themselves and that knowledge of them can only be derived from the
cumulation of indirect evidence. They must largely be inferred from general results in which they are merely one factor, and from symptomatic indications of roundabout character.

The best means of overcoming some of these difficulties is to research a decision process by observation, by the study of organisational records, and by interview. But even then the researcher can never quite be sure whether or not he has been able to capture all the relevant factors pertaining to a particular decision. Unless he is present at every moment when decision-makers converse together, then there are very definite possibilities of omissions and/or distortions creeping into the research findings. It is quite straightforward attending formal meetings but the real difficulties arise over the many informal encounters and gatherings which inevitably occur in an environment where a few individuals work closely together. It is important not to underestimate the impact of the politics of office geography on decision-making practices. A researcher in most cases cannot be present at every informal chat (although many were attended) in cars, over coffee/tea/lunch, in corridors, on stairs and so on. All one can hope to achieve is a description of decision-making which, although incomplete, is acceptably accurate in its essentials. One can only try to avoid a situation whereby the missing pieces do not distort reality to the point where it becomes unrecognisable and therefore invalid. This is an insurmountable problem which plagues much of this kind of research. Although it is possible to insert controls in order to keep distortion to a minimum (these are discussed
in section 6.3 below), this research has proceeded on the premise that what was captured really happened, but that not all that happened was necessarily captured.

6.2 The Changing Focus of the Case Study

In addition to the problems touched on towards the end of the preceding section, dynamic research (ie research on activities through time) encounters more fundamental difficulties relating to the very objectives of a particular project. The present case study on the allocation of DF in the NHS is no exception. Just as those administering services were subject to the vagaries of the wider socio-economic environment which impinged on the NHS, so was the researcher, struggling to adhere to his original objectives, affected by sudden shifts in the environment being observed.

When the research was originally conceived; the aim was to look at the allocation of DF in Alpha over a two-year period, taking in a second health board, Beta, in the second year in order to determine whether Alpha was typical/atypical of decision-making processes in this area of resource-allocation. At the time of embarking on the field work, this approach seemed eminently feasible. But, as the first financial year (from April to March) progressed (during which time observations were proceeding in Alpha) it became clear that the deteriorating economic situation was going to have an impact on spending levels in the public sector, including the NHS. This duly happened(8) and, as a consequence, the second year of the case
study turned out to be a rather barren one financially for health boards. Inevitably this unexpected turnabout in the economic situation (there had been no talk of an impending NHS development famine when the research began) had an impact on the shape of the research project. It proved no longer possible to repeat the observation of the allocation of DF in Alpha in Year 2 nor to discover how allocations were managed in Beta since both boards received very little in the way of DF. In view of the limited funds available, the procedures adopted by both boards in Year 2 did not strictly follow the pattern set by Alpha in Year 1. Although the original schema was upset by these events, the central purpose of the case study remained intact and was not vitiated by what happened. The study was primarily concerned with priorities and with discovering how these were set through the allocation of DF. The fact that such funds became very scarce did not obviate the need for priority-setting to occur. If anything, it meant that the decisions involved were that much tougher. What did change, however, was the environment within which those choices had to be taken. In Year 2, the atmosphere was different from that in Year 1, and the sequence of events followed a different pattern. Obviously, a changed situation demanded a new response from those decision-makers involved in developments. From a setting where developments were linked solely to the acquisition of DF (Year 1), there were moves in Year 2 to discover what scope existed for funding developments from savings or by reallocating resources from 'less important' areas to 'high priority'
ones. Because of these activities, the decision processes observed in Year 2 were less routinised, less orderly and less systematic than they had been in Year 1. Instead, they were somewhat fragmented and disjointed, responding to events rather than anticipating them to a greater extent than usual (than in Year 1, for instance). The perspective of decision-makers shifted from one of expansionism to a commitment to making the best use of existing resources. Lip-service had always been paid to this management task, but in Year 2 the time had arrived to imbue the maxim with substance. Therefore, in line with these changes in the environment being observed, the focus of the case study shifted from one of observing how health boards managed in a climate of steady growth to one of observing how two boards faced up to the difficulties and challenges thrust upon them by reductions in the growth rate. It was possible to witness at first-hand how administrators coped with change in an environment that was already complex, cluttered and uncertain. Quite apart from the numerous internal pressures to which decision-makers were subject, Year 2 illustrated quite vividly the susceptibility of the NHS to fluctuations in the wider external environment.

If incremental theories of decision-making have any validity, then it might be expected that change, if there was any at all in Year 2, would be marginal despite the rhetoric at the time claiming that the 'crisis' created unique opportunities for those eager to introduce long-awaited changes
in how resources were allocated to various competing interests. Following this argument, it is alleged that in times of crisis more significant changes and innovations are possible which rely less upon historical precedent. This is possible because the crisis leads to a dismantling of the existing bureaucratic routines and operating practices and upsets the political balance between different groups within the organisation. A different analysis of the situation suggests that perhaps decision-makers prefer to 'ride out' a crisis without implementing particularly far-reaching changes. There is a refusal to believe that they are entering a new phase of resource shortages and instead a belief that the present cuts are only temporary. These are the sorts of issues which arose in Year 2, but which were far from people's minds in Year 1. Therefore, as the above discussion illustrates, the case study had to deal with two very different years which were by no means similar or comparable (but then perhaps no two years in the NHS are typical). In Year 1, Alpha was observed according to plan. In Year 2, Beta was observed and the procedures adopted by the board in Year 1 for allocating its DF were probed retrospectively. Alpha was observed to a lesser extent in Year 2 in part because there was less activity than in Year 1, a consequence of the lack of DF. In Year 1, the questions raised by the case study centred on the allocation of DF, the procedures involved and the particular individuals involved. In Year 2, these questions were no longer sufficient nor particularly appropriate. The game had changed and new rules were
sought. Questions centred on the scope there was to fund developments from savings and through a reallocation of existing resources. The concern was with better value for money rather than with how much money could be obtained.

New issues entered into decision-makers' calculations concerning possible staff lay-offs, the closure of wards/hospitals, more efficient bed usage, and so forth. None of these possibilities need have concerned decision-makers in Year 1, nor did they to any great degree.

6.3 Data-gathering Techniques

This section is in three parts: (1) the sources from which data were gathered are examined - when, where, and from whom; (2) the criteria for selecting the data are described - what was being looked for, what was recorded, what was omitted, and the way in which the selection process was linked to the conceptual framework outlined in Chapter 4; (3) the mechanics of recording the data are discussed - what instruments were used.

(1) Data Sources

There were four data sources:

(a) observation of selected committees

(b) interviews with selected individuals

(c) analysis of documents relating to the organisation of Alpha and Beta, the allocation of DF, and material on a wider basis relating to the NHS as a whole.

(d) questionnaire circulated to remaining thirteen health boards to ascertain whether observations derived from Alpha and Beta were typical or atypical of similar processes in other boards.
(a) **Observation**

The role of observation generally in social science research should be briefly mentioned before describing the precise form it took in the case study.

The term 'observation' does not imply anything very scientific. In fact, it has connotations of being a rather subjective, value-laden activity. Observation can be haphazard, arbitrary and subjective. But it is also a primary tool of scientific enquiry. For this purpose, observation may be defined as **systematic viewing**, coupled with consideration of the seen phenomena. Many types of data can be obtained through direct observation. If one wishes to obtain data on how members of different groups behave towards one another when some activity brings them into contact, or if one wishes to obtain information on, for example, the manner in which mothers rear infants, then observational methods are more appropriate and yield better results than other techniques. As with other methods used in social science research, observation has some advantages and some disadvantages.

Observation has three principal limitations: (i) the time factor is an important drawback. If detailed information is required extending over time, observation becomes almost impossible; also, it is often impossible to predict the spontaneous occurrence of an event precisely enough to enable one to be present to observe it; (ii) the presence of an observer, it is claimed, may influence the behaviour being observed. Some researchers dispute this, and it is
probably unlikely that any bias associated with this method is greater than with other methods of investigation, particularly if observation is carried out over an extended period; (iii) there are some occurrences which are rarely accessible to direct observation, such as private meetings. As was noted in section 6.1, some of these limitations are acutely evident in studies of decision-making.

Observational methods have three advantages: (i) their greatest asset is that they make it possible to record behaviour as it occurs. Other research techniques depend upon people's ability to recall their own behaviour or to anticipate it. Such reports are usually made in a situation remote from the stresses and strains that influence what the respondent does or says in the ordinary course of events, while he may be influenced by other stresses and strains peculiar to the research situation; the degree to which one can predict behaviour from interview data is at best limited; (ii) observation is preferable in situations where respondents cannot comprehend or articulate adequately; (iii) in addition to its independence of a subject's ability to report, observation is also independent of his willingness to report. It is less demanding of active cooperation on the part of subjects. Of course, people under observation may deliberately try to create a particular impression; nevertheless, it is probably more difficult for them to alter what they do or say in a life-situation than to distort their memory or report of what they have done or said. Through observation one finds out what the individual does, rather than what he says he does.
Gold\(^{(9)}\) has listed four types of observational role: complete participant, participant-as-observer, observer-as-participant, and complete observer. The degree of structure and the degree of participation tend to vary with the purpose of the study. The second and third types of observational role represent the most common use of the observational method. The observer makes his presence known, but attempts as fully as possible to become a 'normal' or 'acceptable' person within the group's activities. There is the minimum of involvement by the observer in a study which is focused on an accurate description of a situation, and this usually requires adopting the fourth type of observational role which was the one adopted for the case study presented here.

Whatever the purpose of the study and the type of observation used to gather data, four questions confront the investigator:

- what should be observed?
- how should observations be recorded?
- what procedures should be used to try to ensure the accuracy of the observations?
- what relationship should exist between the observer and the observed?

An attempt will be made to answer these questions by examining how observation was conducted in the case study of two health boards. Most of the discussion refers to Alpha although it applies more or less equally to Beta.

It was arranged that all meetings convened for the purpose of allocating DF would be attended and observed. These
meetings took place at four levels in Alpha:

(i) AEG  (iii) Advisory Committees
(ii) two DEGs  (iv) Policy and Resources Committee
(proposals then went to full board for ratification which was a formality)

All the meetings in Year 1 were held between February and May, while in Year 2 events were more erratic (see section 6.2 above). The meetings attended were of importance because it was at these that priorities were established and choices made as to how the DF should be allocated (ie who should get, and who should not get, what).

At area level, the main participants were: the Secretary, Treasurer, CAMO and Chief Area Nursing Officer (CANO) and these officers collectively formed the AEG. The Chief Administrative Dental Officer (CADO), the Chief Administrative Pharmaceutical Officer (CAPO), one or two other officers, and chairmen of advisory committees, occasionally had parts to play at AEG gatherings, but only within their own spheres of influence. At district level, the main participants in the two districts were: the District Administrator (DA), District Finance Officer (DFO), District Medical Officer (DMO) and District Nursing Officer (DNO); these officers collectively formed the DEG. As with the AEG, one or two other officers, like the District Dental Officer (DDO), attended meetings of the DEG when requested to do so.

The various professional advisory committees also had to be consulted on whether or not they found the proposed alloca-
cation of DF satisfactory. Of these, three were important: Area Medical Committee, Area Nursing and Midwifery Committee, and Area Paramedical Committee. The chief participants were the committee chairpersons. Advisory bodies representing consumer interests, Local Health Councils (LHCs), were not fully established in Year 1, while in Year 2 their influence on resource-allocation decisions was not much in evidence, principally because there were very few resources available on which to take decisions. (13)

Finally, proposed allocations were referred to the Policy and Resources Committee for discussion and approval. Members of the Committee had the opportunity to question, change, or suggest alternatives. The main participants were the Chairman and committee members. The full board played a very small, and usually unimportant, part. (14)

(b) Interviews

Having observed the various committees involved in decisions on DF, the key participants were interviewed. There were interviews with area and district officers, the chairpersons of the three main advisory committees, the chairman of the two health boards, and board members. (15) The interviews all followed a similar pattern and were informal and unstructured with open-ended, rather than fixed-choice, questions. Questions about how personnel in an organisation conceive of their operations, and how routine organisational decisions are made, require a flexible method and must reflect the ways in which persons in everyday life generally conceive of events. Standardised questions would assume that
both the respondents and the researcher shared similar information about the organisation and operations of health boards.

An aide memoire (16) was used for each interview which listed the topics and issue-areas it was thought desirable to cover in a particular interview. The interviews lasted from half an hour in some cases to over two hours in others, the average length being about one hour. Each potential interviewee was sent a written statement with a covering letter in advance of an interview assuring him/her of absolute confidence. Board members were interviewed in their homes or at their places of work (many had other occupations besides being board members), while officers and other NHS personnel were interviewed in their offices. Some follow-up interviews were conducted with many of the officers. These were carried out in Alpha in Year 2 in order to supplement data gathered from that board in Year 1. Second (and sometimes third) interviews were conducted after a specific development had occurred, or in anticipation of a development. This multiple interviewing technique was useful in confirming the views expressed by a particular respondent in an earlier interview.

Most of the interviews were conducted on a one-to-one basis. In a few instances interviews, or 'semi-interviews' (ie almost collective group discussions) were held with perhaps two individuals or a group of four or five. These discussions were useful because it was often possible to obtain a more rounded and complete picture of a particular
problem or situation than might have been the case in interviews with each individual. In the groups the discussants would occasionally disagree or argue among themselves, or be required to justify their views before others who were also on the 'inside' and who, therefore, knew more than the researcher, who was on the 'outside', could ever possibly know about a particular issue.

Interviews were supplemented with a large number of casual 'chats' over lunch, tea, coffee, in cars, on stairs, over the telephone, and so on. Many of these informal exchanges occurred before or after meetings. One could glean a great deal of potentially valuable information in this way probably because the settings were completely natural. Even informal interviewing techniques inevitably introduce some element of artificiality into a situation.

It should also be noted that interviews were conducted with a number of key civil servants, in the SHHD and the Scottish Office, with responsibility for the NHS in Scotland. Although the case study was not primarily concerned with the relationship between the Department and the two health boards, the SHHD nevertheless has a significant impact on decision-making at health board level. Resources are released by the Department, including DF, and it can impose certain constraints (not always overtly) on boards. Therefore, the relationship between centre and periphery had some bearing on the issues under observation in the case study. This was more in evidence in Year 2 than in Year 1. (17)
(c) Documents
Many documents were received during the research period, most of which were directly concerned with Alpha and Beta and the allocation of DF. Others provided invaluable background material for the research. Documents coming into the former category included reports on the organisation and structure of the two boards and their departments; financial reviews; all memoranda on DF from AEGs to DEGs, from DEGs to AEGs, from AEGs to advisory committees, from advisory committees to AEGs, from AEGs to health board committees; all papers prepared by the boards which dealt with DF, such as lists of proposed developments; minutes of both boards and their principal committees; and a sample of minutes from other health boards to discover how they had proceeded with the allocation of their DF over the same period.

Documents coming into the second category included official reports published by the SHHD on the Scottish NHS; articles on the NHS in newspapers and journals (in particular The Hospital and Health Services Review, and Health and Social Service Journal); academic studies on aspects of the new NHS (eg Brown et al’s study of Humberside AHA); reports of the IOR on planning in the Scottish NHS; and some of the evidence submitted to the Royal Commission on the NHS, especially material relating to the management structure, as well as research papers published by the Commission. All this material was useful because it revealed what was happening in the NHS both elsewhere in
Scotland and in England. This made it possible to note points of similarity, and/or contrast, with the processes being observed in Alpha and Beta.

(d) Questionnaire
At the completion of the case study (ie after the researcher had withdrawn from the two health boards), when several core themes were emerging quite clearly from the data, a questionnaire was devised and circulated to the other thirteen health boards in Scotland. It did not attempt to be comprehensive in its coverage of health board affairs but was primarily intended as a check on the relevance and reliability of the more detailed findings emerging from the case study. The questionnaire findings were perceived as giving some general indications as to where, and in what ways, the two chosen health boards were atypical or conformed to an accepted pattern. Despite attempts to focus the questionnaire on a few key selected areas, the resulting document was still rather lengthy with 51 questions listed. After the questionnaire was circulated, eight responses were received. A reminder sent over two months later to those boards which had declined to reply elicited a further two responses. Therefore, a total of ten health boards completed the questionnaire (ie a response rate of around 75%). Of the three boards which failed to reply, one had sent a letter promising to fill in the questionnaire although nothing more was heard. A possible explanation might have been that at the time there was a changeover of Secretary at the board. Another of the boards was known to the research-
er who had spent a day during the field work period talking to the Treasurer about the introduction of a programme budget system into resource-allocation decisions. Moreover, this board was, at the time, the subject of an intensive inquiry by a research team under Professor Maurice Kogan from Brunel University commissioned by the Royal Commission on the NHS. Perhaps the officers of the board were of the opinion that they had received sufficient attention by academics!

The questionnaire touched on a range of matters, from basic factual questions concerning the structure of boards (e.g., relations between areas and districts, the operation of consensus management, committee structure) to more searching inquiries about DF and their allocation. Most of the questions of this type were formulated as a direct result of the data gathered by the case study. A questionnaire is not always the ideal instrument for exploring sensitive areas or for probing decision-makers' actions and motives. Notwithstanding these difficulties, only a few of the responses to the more sensitive questions were perfunctory (i.e., gave away nothing). Most of the responses were quite full and conveyed a flavour of the problems confronting officers. Certainly it can be concluded that as a check on the more detailed observations, the questionnaire was a worthwhile venture. Its findings are incorporated into the discussion in Part 3 where appropriate.

(2) Criteria for Data Selection

Observation of committees, interviews with participants and analysis of documents were
aimed at eliciting information which would achieve the study aims set out in Chapter 1. The questionnaire was a means of providing a check on the detailed observations and, in addition, a basis for making some generalisations from the particular. With the conceptual frame of reference presented in Chapter 4 in mind, the following paragraphs describe how particular data were selected, and examines the selection criteria employed.

(a) Observation of Committees

Observation was conducted at board, area and at district levels. At board level, observation was aimed at discovering how board members conducted their affairs and how, in particular, they handled decisions relating to the proposed allocations of DF prepared over the preceding months by various officers at area and district levels. How did board members perceive their role? Would they simply ratify the proposals with no discussion? Would they raise questions and, if so, who would raise them, and what sorts of questions would they raise? By observing in Alpha, for example, the meeting at which the allocations of DF were discussed (one item on a lengthy agenda) it was possible to see how members approached a whole range of issues, from rather 'trivial' items to more 'important' ones, like DF, affecting the provision of services over the whole area under the board's jurisdiction. The main purpose of observation at this level was to identify the degree of participation in decisions (measured by the amount of discussion among board members) affecting DF, and the form this took (measured by the kinds of questions, if any, asked).

Observation of the two AEGs was confined to those meetings which dealt partly, or exclusively, with DF. It was aimed
at providing data of three types (the categories are somewhat artificial in that the boundaries between them are not in reality mutually exclusive; their purpose here is to enable the process of selecting data to be broken down as far as possible for ease of comprehension, and to link the data with the categories used in the conceptual framework):

(i) **structural data** on the organisation of the two AEGs - who, if anyone, chaired meetings, the format of these, and the operation of consensus management; (ii) **personal information** on the participants - their interaction, their backgrounds, their use of bargaining strategies, and their handling of disagreements should any arise; (iii) the **content** of meetings was noted - the sorts of contributions made, the kinds of information used and whether these were of a 'hard' statistical, quantitative type, or whether they were of a 'soft' qualitative variety based largely on value judgements, experience and intuition. Observation of the four DEGs (two in each board) followed the same pattern.

Observations of advisory committees were confined to one committee in Alpha. Although attempts were made to attend relevant meetings of other committees arrangements could not be made in time. Observations obtained from this one committee revealed how it examined the proposed allocations of DF referred to it for comment by the AEG.

(b) **Interviews with Principal Participants**

The interviews were designed to supplement observational data, and enabled the researcher to discuss with particular individuals their reasons for adopting particular
stances on issues to the exclusion of possible alternatives which might have been available. The interviews covered matters which seemed significant from the observational part of the research and, in addition, were intended to find out something about those being interviewed - their backgrounds, the environments in which they worked, aspects of the organisational structure which affected them, and the impact of all these factors on decision-makers' contributions to the process being observed. The intention was to pursue these broader topics while paying particular attention to DF and their allocation.

Each interview schedule, or aide memoire, raised similar issues which varied slightly according to the interviewee and his/her position in the organisational structure. Naturally one wanted to learn certain things from a Secretary that one would not expect a CAMO to be an expert on, and vice versa. Most of the questions and issue-areas were derived from observations, and from the theoretical concepts discussed in Chapter 4. In order to try and discover to what extent rational, and/or incrementalist, theories of decision-making fit the data, it was necessary to obtain data on the kinds of information utilised by decision-makers, the bargaining strategies deployed by them, and the possible constraints in existence which might have prevented them from pursuing what might be considered more comprehensive, rational methods of resource-allocation.

The topics generally covered in each interview fell into three categories: the management structure - its composi-
tion, operation and aims; **priority-setting** - how DF were processed and allocated; and the **budgeting system** - the importance of DF, the mechanics of the budgetary process and its impact on the allocation of DF\(^{(21)}\) Questions on these topics were designed to elicit information on the allocation of DF in particular, but also data on the whole environment in which these decisions were taken. The factors and influences impinging on specific decisions were multifarious and were difficult to pinpoint and isolate since they stemmed from the wider organisational system.

By absorbing as much as possible of the overall atmosphere of Alpha and Beta, and by learning something about the total environment, one could begin to compose a picture, however incomplete and imperfect, of the allocation of DF.

(c) **Analysis of Documents**

Although not quite as essential as in an historical study, or one where access to individuals or meetings is prohibited, the acquisition of documentary material usefully supplemented data from other sources, filling in gaps and providing background to various moves made by decision-makers. Official minutes, as is invariably the case, gave away very little, covering events in skeletal fashion. However, they provided a useful check to ensure accuracy of factual data collected during observation. Of course, very little actual discussion was reproduced in the minutes. Other documents such as odd reports, internal memos, and financial statements were also very useful in providing additional data. For example, Beta had set up a working party soon after the board had been established in 1974 to
report on the provision of existing services within the area and, as far as possible, to assess the health needs of the population. This document conveyed some idea of the kinds of priorities shared by board members. There were also papers put before the boards by their officers which suggested ways in which DF might be allocated. These were usually prepared by the Treasurers' departments and an examination of them revealed the basis upon which lay members were expected to decide allocations. It was possible to note the sorts of information contained in the papers and the options, if any, from which board members were asked to choose.

(3) **Recording the Data**

Two techniques were employed to record data:

(a) observations of committees were recorded in a notebook

(b) interviews were recorded on a cassette tape recorder.

(a) **Note-taking**

All observations of numerous committees in both health boards were recorded in a notebook during actual meetings and written up in full as soon as possible after the completion of each observation period (usually a few hours at most). Inevitably there was some selection of what was noted and what was ignored. The general rule was that only those pieces of information which illustrated the direction of an argument or discussion, and those which revealed personal characteristics of the participants were recorded. This did not require noting everything that was
said by participants but it did necessitate recording a
great deal of the exchanges between individuals. Taking
notes while 'sitting-in' with officers and others did not
appear to be obtrusive and there was no indication that it
upset or disturbed normal patterns of interaction. Possibly
there was a sharp increase in the frequency of humorous re-
marks made during a meeting but beyond such peripheral
matters there were no other visible distortions.

In writing up the notes after each meeting or visit,
Schatzman and Strauss's(22) model was useful for recording
observations. It comprises three categories for organ-
ising material:

(i) **Observational Notes** - statements bearing on
events experienced through observation. They
contain as little interpretation as possible, and are as reliable as the observer can con-
struct them. Each ON represents a piece of
evidence for some proposition. An ON is the
who, what, when, where and how of human
activity. If the observer wishes to go be-
yond facts, he writes a Theoretical Note
(i.e an inferential note).

(ii) **Theoretical Notes** - attempt to derive meaning
from ONs. The observer thinks about what he
has experienced, and makes whatever inference
of meaning he feels will bear conceptual
fruit. He interprets, infers, hypothesises,
conjectures; he develops new concepts, links
these to older ones, or relates any observa-
tions to any other.

(iii) **Methodological Notes** - statements that re-
fect operational acts completed or planned:
an instruction to oneself, a reminder, a
critique of one's tactics. They note timing,
sequencing, stationing, stage setting, and
manoeuvring.

These recording tactics, according to Strauss and Schatzman,
are intended to provide the researcher with a continuous,
developmental dialogue between his roles as discoverer and
as social analyst. The sorting problem and recall problem make systematic recording procedures essential.

(b) Recording

The majority of interviews were recorded on a portable cassette recorder. It was felt that this was the most unobtrusive means of recording information and also the most accurate, particularly since the intention was to make extensive use of quotations by decision-makers. At the start of some of the interviews, the interviewees were perhaps slightly uneasy at the prospect of being recorded. However, as the interviews progressed, respondents would relax and invariably forget about the existence of the tape recorder. Officers were most at ease during recorded interviews, possibly because many of them were accustomed to using recording machines in their administrative work. Occasionally during an interview, an officer would request that the machine be turned off while he/she explained a particular action or whatever. Their requests were always complied with.

Not having to scribble down what was being said during many lengthy interviews left the researcher free to concentrate on the actual interview and to direct it more smoothly, and with more control than might have been possible had one been absorbed with the sheer mechanics of recording data manually. Transcripts were prepared from the recordings, if possible soon after the interview but in a number of cases not until some months after the recording was made. A major disadvantage, perhaps the only one, with recording interviews is the length of time it takes to
prepare transcripts, ie roughly eight times the length of the original recording (eg an interview of an hour's duration can take up to eight hours to transcribe). For a researcher working alone with no supporting staff this is a time-consuming business. The case study involved between 50 and 60 hours of recorded material which had to be transcribed. In addition, there were a large number of informal conversations and chats which were not recorded on tape. Sometimes these occurred after interviews when the recorder had been switched off, or over lunch, etc. Notes were made of these casual encounters as soon as possible after they had taken place.
PART 3

THE CASE STUDY
THE POLICY TRIAD:

DRAMATIS PERSONAE (1) HEALTH BOARD MEMBERS

To understand what happens when health boards (or, to be more specific, the two boards selected for close study) allocate resources (in this case development funds) requires opening up the 'black box', investigating the behaviour of the elements which make up the policy triad (health board members, officers, advisory groups), and examining the structure of the relationships between them.

The description which follows of this policy triad is presented in three stages: (1) the individuals who comprised the decision-making process observed in the two health boards are described; (2) the organisational forms adopted by each group of actors for its purposes are outlined; (3) the individuals and their occupation of the organisational forms are analysed in the context of a particular decision process (development fund allocations).

This, and the next two chapters, are devoted to the first two stages (ie a description of the individual actors and the organisational forms they inhabited). Chapters 11 to 13 are concerned with the third stage.

The description of the policy triad is based on the assumption that many of the differences between the groups of actors, who comprise the triad, are fundamental to an understanding of resource-allocation decision-making in the NHS at a local level. The data in this chapter are drawn from three sources: the study of two health boards, the
questionnaire circulated to the remaining thirteen boards, and from the relevant literature. The origins of particular observations are given in the text where appropriate.

7.1 Health Boards: Appointment v. Election
Health board members are appointed by the Secretary of State for Scotland for a four-year term, the appointments being so organised that half of the members of each board retire every two years in order to ensure continuity. Appointments are made on the basis of nominations received by the Secretary of State from a variety of interested bodies, including local authorities, trade unions, voluntary bodies, business groups, church organisations and professional associations. Since members are not elected, they lack a direct power base located in the community (the larger the board, the more apparent this is). Moreover, board members are appointed for their contributions as individuals and not as representatives of their respective nominating bodies (see further below). In short, board members are not accountable directly to the local community for what their board does, or does not do, but are accountable upwards to the Secretary of State. The fifteen health boards are his agents.

The Secretary of State, although in theory free to appoint anybody with an interest in health care to serve on health boards, operates within constraints. There are two main ones. First, there is not a limitless pool of potential board members from which appointments can be made. It is likely, therefore, as a corollary of this, that the number of individuals both willing and able to serve in a public
service capacity is limited. This probably explains to a large extent why existing health board membership closely resembles that of the old RHBs and BoMs. A second constraint stems from the requirement to appoint members from specific groups - doctors, nurses (and other health care occupations now), trade unionists, those active in voluntary bodies, survivors from the pre-1974 boards, and local authority members. Most of these groups comprised the pre-1974 authorities, and they also provide the source of membership of Local Health Councils (LHCs). It should be pointed out that the Secretary of State can reject nominations which reach him and ask for new names. At the end of their four years, board members can be re-appointed if they wish to be and if the Secretary of State so desires.

The justification for an appointment system is that 'direct popular election of board members has not, in the past, met with any support'. A few students of the NHS are critical of the system, including Cameron who claims that 'the new act is retrogressive in one very important way. It is undemocratic'. He proceeds to argue that 'where there are scarce resources there will always be a problem of how best to use them. No appointed body can possibly say how this would best be done in a particular locality'. Cameron believes that there is a danger that appointed boards may 'pay more attention to the occupation and amusement of professional people than to the health needs of the community'. Whatever the validity of Cameron's arguments, the government remains to be persuaded by them. In any case,
most of the proposed alternatives to the present model foresee the time when the health service is part of local, or regional, government.\(^{(6)}\)

In an effort to overcome what was widely perceived as management bias in the reorganised NHS, the incoming Labour Government in 1974 committed itself to reviewing the organisation of the NHS with the aim of making it more democratic and less bureaucratic. In fulfilment of this promise, a document\(^{(7)}\) was issued in July 1974, *The NHS and the Community in Scotland*, which suggested changes designed 'to make the system more responsive to the views of those it serves and to take greater account of the contribution which those who work in the service can make to its management'.\(^{(8)}\) But the proposed changes did not involve any moves towards elected boards, amounting to little more than tinkering with the status quo.

Although in some quarters it would be verging on heresy to admit it, appointed boards have at least one redeeming feature. Under an appointment system it is possible to appoint members with a variety of interests and expertise which may prove useful on health boards. The document cited in the above paragraph noted that 'where possible, room should be found for people with a genuine interest in the health service ....'\(^{(9)}\) Apart from the obvious categories, eg local authorities, trade unions, health care professions and staff, and universities, 'it will often be useful for boards to have members with business, legal and financial experience'.\(^{(10)}\) Moreover, 'appointment by the
Secretary of State makes it easier to ensure that advantage is taken of overlapping interests in nominations and that regard is had to questions of geographical distribution of membership, age, etc.\(^{(11)}\) It is conceivable that elected membership could give rise to a number of imbalances between the representation of various interests and so on. Moreover, if local authority elections attract low turn-outs, how much enthusiasm would be generated by health board elections?

More important than the arguments over appointed or elected health boards (including control of the NHS by local government) is the problem of whether board members are able to perform satisfactorily the role prescribed for them and whether, in fact, this role is one for which members are best suited. The ability, or inability, of members to fulfil their functions adequately is a pertinent issue and the performance of these functions suggests that neither an appointment system nor a system of elections makes, or would make, a great deal of difference to the final outcome. To confine discussion to the issue of appointment versus election, as Cameron and others have done, is to miss the very real problems facing lay members on health boards. As Haywood\(^{(12)}\) argues,

\begin{quote}
a debate confined to the merits of election rather than selection of members of health authorities will, however, bypass the equally important issue of how 'public representatives' (members of health authorities) can make an effective contribution to the local management of the NHS. (The) election of members of ... health authorities does not, for example, mean that they will be much more in command of events than their predecessors
\end{quote}
are now; the difficulties local councillors have in asserting control over services for which they are supposedly publicly accountable warn against such easy assumptions.

Heclo's study of councillors in one local authority supports this conclusion. Also, Hill has described the many councils in which it is the officials who are the major influence on policy-making. Furthermore, on a national level similar problems are encountered between Ministers and their civil servants.

It is necessary, therefore, to discover the contribution which health board members are able to make to the policy-making process, in the light of the constraints which hinder a full realisation of members' potential. To quote Haywood again,

the present contribution of members is determined by more than the formal descriptions of their powers. Indeed if the comments of many members on their lack of impact are anything to go by, it falls short of the role envisaged for them in the reorganisation blueprints. Some constraints arise from particular personality traits, others derive from problematic relationships between different groups of actors in the policy-making process, and others are structural in origin. The first two sets of constraints may be expected to fluctuate, depending upon the characteristics of the role occupants. But constraints of a structural type are likely to remain unchanged until structural solutions are found for them.

Observation of the two health boards, Alpha and Beta, revealed the presence of a number of constraints which can be grouped, for convenience, into four categories (not
mutually exclusive) for descriptive purposes: (1) the composition and functions of health boards; (2) the organisation of health boards; (3) the demands on health board members; (4) and the relationship between board members and chief officers. Board members attempted to cope with these obstacles in various ways, and the coping strategies employed are described after each set of constraints has been examined.

7.2 Composition and Functions of Health Boards
The role of board members since the reorganisation of the NHS has been conceived primarily as a policy-making one rather than as a representative one. As indicated above, membership of health boards was supposed to be on the basis of individual management ability (defined broadly in terms of monitoring the activities of area officers) as opposed to interest representation. Successive official documents have emphasised that 'members are appointed for the contribution which they can make as individuals' and that 'it must be clear that they in no sense represent the interests by which they were nominated'. The SHHD annual report for 1974 states: 'Members are expected to participate fully and objectively in the work of the board and to share responsibility for all decisions of a management authority directly accountable to the Secretary of State'. Therefore, board members have a managerial role in their policy-making and monitoring activities, while executive management rests with officers at area and district levels.
To maintain some contact between the community served by a health board and the management of the health service, there are LHCs. But contact is also ensured through the device whereby a proportion of the membership of health boards comes from local government (regions and districts). As noted earlier, members are not drawn entirely from outside the NHS. 'Members ... should include some drawn from professionals engaged in the NHS who would, however, be appointed in a personal capacity and not as representing a particular professional interest'.

Table 7.1 shows the breakdown of membership among the various groups entitled to nominate members to Alpha and Beta.

**TABLE 7.1 Breakdown of Health Board Membership**

<table>
<thead>
<tr>
<th></th>
<th>Max.no.of Local govt members</th>
<th>Nominees</th>
<th>Nominees</th>
<th>Prof.s.noms.</th>
<th>Noms.</th>
<th>Noms.</th>
<th>Noms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha</td>
<td>20</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Beta</td>
<td>18</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1 Numbers exclude chairmen of boards  
2 Normally there is (as above) 1 member from the regional local authority and 1 from each district local authority.

Health board chairmen are part-time and they receive a part-time salary for their services. Board members are also part-time but they serve on a voluntary basis, receiving only allowances.

The membership of Alpha and Beta was reasonably typical of that of most other health boards. The majority of board members (including chairmen) were men; six females served on both Alpha and Beta. Linking this information to that
obtained from the questionnaire which was circulated to the remaining thirteen health boards, to which ten responded, showed that the average number of females serving on boards was four, compared with an average figure for men of fifteen. Therefore, the number of women members on Alpha and Beta was slightly above average. Out of a total of twelve health boards, there was only one female chairperson and one female vice-chairperson (neither were members of Alpha or Beta).

The majority of board members on Alpha and Beta were middle-aged or over. Again, this was typical of the boards surveyed in the questionnaire. The average age was around the mid-fifties; only one board gave a figure below fifty for its members' average age (ie forty-nine). All twelve health boards had a large proportion of their membership made up of those with previous experience of health service administration. The average figure was eight, with larger boards having up to fourteen or fifteen members with previous experience. Smaller boards had around five members in this position.

Those nominees to boards not coming from the main interests (ie local government, trade unions, health care professions, universities) came from a wide variety of backgrounds. Some of the appointments reflected the nature of the area being served by particular boards. For example, those boards with a rural bias had farmers as members, whereas boards in urban-industrial areas had businessmen and/or industrialists as members. Most of the twelve boards had at least
one housewife as a member, and usually two or three board members were retired.

It was stated in Chapter 3 that a health board's purpose is to deal with 'major policy, strategic planning decisions, the broad allocation of resources and matters of substantial interest to the community'. Evidence obtained from Alpha and Beta suggested that board members experienced great difficulty in identifying with this rather broad, and vague, definition of their role, and in ascertaining precisely what was expected of them. This was a separate problem from that arising from the various constraints which impinged upon members who were trying to fulfil their role. A further circular on the functions of health boards did not clarify the situation. It stated that the function of boards was to take an overall view of the needs of their areas throughout the whole field of health service provision, to develop policies for the most effective provision of services in the light of general policies laid down by the Secretary of State and the resources available, and to watch over the implementation of their policies and the day-to-day management activities of officers.

The official view of board members' role was expanded in a paper delivered at a health service conference in May 1973 by a civil servant at the SHHD. He made it clear that although health boards would on occasion be concerned with detail, this contact with the detail of things would be very selective and not general. Health boards had to
avoid becoming 'enveloped in a welter of detail'. The relative roles of boards and their officers would move more in the direction of the relationship between Ministers and civil servants. The boards would, in general, be concerned with principles and their officers would give effect to these through a wide range of detailed decisions.

An observer\(^{(24)}\) of the NHS has written that members of English health authorities (RHAs and AHAs) 'experienced a fleeting impression of being trapped in a web spun by theorists and management consultants'. Most board members, it would be fair to say, have experienced similar feelings. These have given rise to a gap between the role of board members as defined officially, and the role as board members themselves have interpreted it.

Few members interviewed were clear about what was meant by the terms 'major policy', 'strategic planning decisions', or 'the broad allocation of resources'. If asked to define what they understood by them, most members referred to capital schemes or to projects involving some physical, or institutional, development. The association between planning and capital schemes was noted by Hallas\(^{(25)}\) in his study of CHC members. He wondered why it was

\[
\text{that very often council members and officers discuss 'planning' as if it was all about buildings? Time after time, especially when 'strategy' documents are debated, the talk centres around the provision of new accommodation, the possibilities of change of use of buildings, and the probabilities of closures. It rarely happens that a member of a study group of the council remarks that planning is more a question of rearranging services to the patient or client'. (26)}
\]
Hallas argued that the 'planner' in the hospital side of the NHS had come to be identified 'as overwhelmingly concerned with capital works or, in other words, new buildings'.\(^{27}\) In a research project undertaken for the Royal Commission on the NHS,\(^{28}\) a useful distinction is made between strategic planning (ie overall framework of priorities and resource availability, etc) and operational planning (ie the definition and execution of specific developments). The research team found that conceptions of planning in the field did not always correspond to these definitions. There was a tendency among respondents (including health authority members) 'to confuse planning of capital projects with the whole planning operation ...'.

Apart from apparent confusion, board members possibly focused on new buildings because they liked to see things done. What better indication could be given of their ability to develop the service in an area than the establishment of a new District General Hospital, or maternity unit, or whatever. Developments like these were highly visible, whereas with community care services which, one could argue, are in much greater need of development, the opposite situation obtains, improvements in this area, like employing more health visitors, having a low profile and the benefit to the patient by having increased staff establishments, being difficult to measure. In many of the interviews with board members,\(^ {29}\) questions of policy, planning and priority were answered by way of reference to particular capital developments. For a number of members
of Alpha, the most important priority was a new District General Hospital. For many members of Beta, their top priority was a new Royal Infirmary.

A further aspect of the inability of board members to feel at ease with a broad policy-making role might be that, apart from capital projects (which form only a part of what planning is supposed to embrace), Alpha and Beta did not indulge in much conscious policy-making. In the words of a medical member of Alpha, 'there is no conscious planning process in the NHS - priorities are buried within "shopping lists" of developments and deficiencies and board members have little role to play in decisions of this nature'. A board Secretary(30) shared these views. 'There aren't enough policy decisions to make it worth their (ie board members') while'. This had led to problems in finding sufficient work for the board. The Secretary claimed that 'the majority of boards are probably having to put up items which normally wouldn't be taken to the board merely to put a facade on'. In other words, agendas for board meetings were occasionally 'manufactured' in order to occupy members. The entire subject of planning and priorities was a crucial one and it posed one of the central, if not the central, problems which faced board members.

If board members experienced role confusion, then health board chairmen and officers had even greater difficulty in defining a board's role in any but the vaguest of terms. As one might have expected, chairmen were among the most
ardent supporters of health boards and their new managerial role. In an unpublished paper (31) delivered at a conference in 1974 on the role of a health board and its members, the chairman of Alpha was anxious to emphasise that board members must keep their work at the correct level, ie the making of policy. 'We must set our objectives and be in a position to check the progress of our activities'. Officers had the responsibility of carrying out a board's policies, and the day-to-day management of the service. The chairman drew attention to a possible danger. 'It may be that board members tread the corridors of power, but it is necessary that there is no feeling of isolation from the operational effectiveness and standards of the service given at customer level'. (32) Nevertheless, the chairman found it extremely difficult to define what he understood by broad policy-making. 'I find this very difficult to define (ie the whole area of broad, overall planning). It's a case of playing it by ear up to a point ... . What people have gradually got to understand is that there comes a point where they have to stand back and out of it'.

The Secretary of Beta felt that the term 'policy-making' had not been defined. The role of board members 'has never been adequately defined. It might have been useful if the Department (ie SHHD) had given board members a job description ... . Board members are asking what are we here for ... . It's very difficult'. The chairman of Beta explained that he would put under the term policy 'almost everything because it does tend to percolate up (from the
districts, to the area, to the board). But this chairman, in addition to many board members from both boards, was concerned at his lack of involvement in the formation of policy. 'It has been troubling me for some time that we were not really formulating any policies at all'. There were numerous explanations for this state of affairs, many of which lay outside the board's competence. For example, the board had inherited commitments to projects from the pre-1974 RHBs and BoMs; the cuts in the growth rate of the NHS; and the policies which the SHHD were imposing on health boards and with which the latter were obliged to comply. It was perhaps significant in the context of a general feeling of impotence experienced by board members that the SHHD's memorandum on strategy within the NHS until the early 1980s, The Way Ahead, was received enthusiastically by members. It provided them for the first time with guidelines within which they could work and objectives towards which they could aim.

Only one member of Alpha was enthusiastic about his role. It was probably no coincidence that this member was also a top executive in a thriving industrial enterprise. His views were atypical but are worth noting. To him 'the health board is at the end of the day an industry ...'. Running a health board is analogous to running a large company ... . It has an end product which is a sick customer made well'. This member had sat on numerous boards during his career and the experience gained had equipped him well for his present role. A firm believer in modern manage-
ment concepts like corporate planning and strategic planning, as opposed to piecemeal tactical planning, he claimed that it is 'the health board's function to plan, to guide and to direct, but not be involved in the day-to-day running of the services'. In short, he equated the health board with a board of directors which confined itself to policy and strategy. 'I don't like seeing a report more than a page long', he added. The chairman of Alpha wanted to see all board members visualising their role in similar terms. 'I find', he said, 'that if you get people coming into the service from industry who've been involved in top policy-making decisions they can accept our role quite easily'. The vice-chairman of Beta, who had a business background, saw his board's function in exactly the same way. 'We are not a board of management we are a directorate'.

To some extent, the dissatisfaction with their role experienced by most board members in Alpha was natural and might have been short-lived. After all, there is always reaction against change.\(^{35}\) Doubtless much of the nostalgia for old times expressed by members, especially those with previous NHS experience, stemmed from an innate conservatism. However, even allowing for this, the consensus among members from different backgrounds, and with different experiences of the health service, on what was wrong with their present role suggested that this was too facile an explanation of the total situation. The health board structure, while different in most respects, was akin
to the former RHB structure in its remoteness from the point of service delivery. One might have expected, therefore, that for former BoM members (who were much closer to the point of service delivery than members of RHBs) being part of a health board would have been totally alien to what they were accustomed to prior to 1974. The personal involvement with staff and institutions was no longer possible, nor was the executive involvement in day-to-day decision-making. However, board members with previous RHB experience, as well as members with no NHS experience at all, were not entirely content with their duties. Criticism centred on two specific areas: (1) a lack of involvement in decision-making; (2) a great deal of decision-making over resources and priorities had been taken out of the hands of board members and was the responsibility of the officers. A common complaint was that health boards were becoming 'rubber-stamping' agencies.

Part of the confusion about functions lay in members' reluctance, or refusal, to accept or adhere to the managerial overtones of the role as officially prescribed with its emphasis on broad policy-making. This was acutely evident among those members who had been members of health authorities before reorganisation when their role had been undisputably a representative one. One board member with long experience of health service administration said:

members have a different function now and not, so far, one which I have found rewarding in comparison with the old BoM. As far as I can see the health board is a 'rubber stamp' rather than an active participant ... . I don't find my role now rewarding - I'm too far away from
the people on the ground ... . I'm frustrated, I'm not contributing a great deal at the moment. In the old set-up I did feel that we got our teeth into things and we were near the grass-roots. I realise this is not our function. But I don't find our new role so rewarding.

Many board members did not feel sufficiently involved in decision-making. This comment by one member was typical:

I know we're supposed to be at the policy-making level but I think that that's a wider sphere than sometimes we interpret it. It's awfully easy to say that the executive group at area and district levels should be involved in the detail but I think it could be a bad situation if we stuck strictly to the letter of our remit and confined ourselves to a policy-making role. I don't think we could possibly have the knowledge to be policy-makers without being involved at a lower level ... . I think the time will come when we will want to ask ourselves, what is our role and function vis-à-vis the LHC? If we want to feel that we're still very necessary, we may have to become much more involved.

Another member, also a consultant, believed that the policy-making role for members had two disadvantages: (1) a member lacked full knowledge of any problem; (2) a member was of necessity dependent on officers for information. Invariably, the recommendations of the AEG were usually accepted by board members. It was, claimed this member, very difficult to do otherwise. 'If members want to influence decision-making then it is not sufficient for them to read agendas, minutes and attend meetings'. It was not easy for members to perform a policy-making role without detailed information and knowledge of a particular situation.

Another member reiterated much of what has been said.

Anyone who came on (to the board) without previous experience of BoM work would find himself unable to make very much of a contribution; unless he
were a specialist - a dentist (etc.). If he were just an ordinary fellow who was recognised as being interested in voluntary work he'd find it very difficult to define his role other than to listen to what's going on and give an opinion.

Other members with former experience of health service administration felt that perhaps new members had an advantage over them precisely because they did not enter the new service with preconceptions about what they ought to be doing. One member referred frequently to her 'BoM outlook' which prevented her from being totally at ease in her new position. 'I've always had a BoM approach, which is more detailed. I don't like having to make decisions without knowing all you used to know... . You knew what was going on under the BoM system ... . I don't like not having quite the same niggling role'.

From the interviews, it became clear that board members were constrained not simply by their formal role description but also by particular characteristics of their role performance, the conception members had of their role, and the constraints associated with it. In addition, the policy-making role itself may be based on a misconception. Haywood(36) maintains that 'the view of them (ie board members) as policy makers, thirsting to choose between options presented to them by officers may influence management structures but it hardly matches either the abilities or preferences of many public representatives'. It was clear from members' own conception of their role that, while a few might pay 'lip-service' to its policy-making dimension, most in fact performed their functions differ-
A desire for the more detached role of policy-making is far from universal.\(^{(37)}\) To refer once more to studies of local councillors, these suggest that councillors have interests in specific issues as opposed to some corporate view of the problems with which they are concerned.\(^{(38)}\) A former principal officer in the manpower division of the CSA accepted that there was still a desire for members to become involved in detail. This is understandable. Members can comprehend details. They like to make a positive contribution and see the results of their efforts in direct, practical ways. It may be that members ought to make such a contribution since officers may not be as interested as lay people in such a task. The problem is partly that of the division between policy and administration and whether such a division is possible. They can't in practice be separated. Members are better equipped to become immersed in detail. Certainly many are not equipped for the present policy-making role of health boards. \(^{(39)}\)

The chairman of Beta identified two functions of health boards. One of these, the policy-making function, has been examined, but there is another, a public relations function, which is sometimes overlooked, or not given sufficient stress. According to this chairman, board members should get around as much as they could by meeting the public who used the services in an area, and the staff who provided and maintained the services. It was vital that the board should not appear remote. This social role was to be performed in conjunction with members' more formal tasks. Quite often, the social commitments could be more time-consuming than the formal role. Numerous social gatherings, opening ceremonies, and informal meetings with groups of staff at different hospitals, or with
LHC members all had to be attended and/or supported. Above all, it was important 'to be seen'. In fact, most members enjoyed the public relations function, saw it as a vital part of their work, and wished they could devote more time to activities of this kind. Nevertheless they could give rise to logistical problems (see below).

A source of tension for some members was the relationship between them and the LHCs in their area. In terms of their respective functions as officially prescribed there ought not to have been any conflict. Board members, as already noted, were supposed to take a broad, detached overview of the Service, while LHCs were to become more involved in the 'nitty-gritty' - representing the consumer, albeit indirectly, by monitoring the standard of services and facilities in hospitals, clinics and so on. To some extent, LHCs have taken over much of the role of former members of BoMs but without the latter's executive responsibilities. Tension arose, however, in those instances where board members were unable to identify with a broad policy-making role. This led them to perceive their functions in similar terms to LHC members. For example, a local authority member of Alpha firmly believed that a health board was necessary because 'at least the local people know there are people they can go to if they have a complaint. I have people coming to see me as a health board member. We've got to keep communication as near to the people as possible'. This member did 'small personal things for people. I don't raise them at board level.
The board makes policy and is concerned with the big things.' Another member of Alpha did not see his role in strictly managerial terms although he appreciated that this was how the Secretary of State looked upon the functions of board members.

I don't think I could divorce myself from my community. If Mr X was in trouble I would see it as my job to help. This is where I find LHCs so troublesome. I don't see how one can divide the functions of LHCs and health boards in a clear-cut way. You can theoretically, but not in practice.

For many board members, the uncertainty of their role, coupled with the feeling that they should also maintain contact with the community and not become remote, faceless policy-makers, brought them into an uneasy relationship with LHCs which, at the time, were just being set up. The vice-chairman of one of the boards believed that there was a problem over who was more representative of the people in an area - the health board or the LHC? 'We (ie board members) want to represent the people too. It's not just a LHC function. There's a feeling that the health board's interests and views are in some way different from those of LHCs'. Many board members shared similar opinions. 'I'm as near to the grass-roots as a LHC member', said one, who believed there were advantages in having local people on health boards so that

the public at large can get hold of those people, who are not faceless, but people they know and meet on the streets who have no allegiance to the Secretary of State. I see myself as representing the public and this is where potential conflict with LHCs arises.
Some members expressed ambivalence. On the one hand LHCs were 'a good thing'; on the other hand they were 'a real worry' because 'none of us know what our position is in relation to them'. Moreover, there was a fear that 'they (ie LHCs) will know about things before we do'.

Remarks like these perhaps confirmed one Secretary's view that 'board members tend to see themselves not as managers but as representatives of a community, or stratum of society, or profession'. However, there were other members (probably a minority) who welcomed the arrival of LHCs and saw them as being of tremendous value in informing boards of conditions in hospitals, etc. One member saw the two bodies as complementing each other. They 'should work together ...'. Something is needed in-between the public and health board'. Another member went into greater detail, and hoped above all that LHCs would confine themselves to 'small things' and not try to do 'the big things'. 'My hope is that LHCs will pick up the small things and keep sending these ... to the board so that (they) can be dealt with ...'. Nevertheless, this member's enthusiasm for LHCs was qualified. He hoped LHCs would not become involved in priority-setting or in raising expectations among the public that could not be fulfilled. 'If they (ie LHCs) think their role is to run the service or see that what they want is got without regard to other priorities or to the limitations of finance or the advice of anybody then it's going to be a great pity'.
It was pointed out at the start of this section that board members were appointed in their capacity as individuals, not as representatives of particular interests, professions or geographical areas. But, as the Secretary quoted in the first sentence of the previous paragraph observed, many board members either found it very difficult to refrain from representing a particular view, or else were of the opinion that this was what a board member should be doing. Clearly, the way in which the appointment system operates makes it difficult to visualise how, or indeed why, board members should think otherwise. After reviewing the range of interests entitled to submit nominations (strikingly similar to the pre-1974 composition of hospital authorities), Brown(41) concluded that 'it hardly seems likely that this will throw up groups who will be able to look sectional interests in the face and decide what is best for patients. Membership will be on the basis of interest representation rather than management ability'. Comments from board members supported this assertion. One member of Alpha, with previous experience of NHS administration, said: 'I know one's not meant to represent one's own area, but one is bound to stand up for one's area on certain occasions. Inevitably one knows more about one's own area than anywhere else'. This was an important consideration when, in this member's view, it was 'beyond anyone's capacity really to take an overall view (of the service)'. Another member, in defining his role, said:

I would try not to define it as representing a
particular area. That's the first thing, I'd try to avoid, although it's very difficult to avoid looking at your own particular area and saying 'What's going to happen to (X), or is (Y) getting a fair crack of the whip?' You tend, at times, to say 'I can't make a contribution to the total object of the service in the whole area, therefore I'll try to make a contribution to a part of it' - the part you are residing in and (about which) you can get real information.

Apart from the potential for geographical specialisation, there was also scope for functional specialisation. Certain board members had leanings towards (one would express it no stronger than that) particular services such as, for example, geriatrics. Other members were already specialised by virtue of their professional backgrounds. This was obviously the case among medical and nursing members of boards, but even a few local authority members had acquired some expertise concerning those services which had, prior to 1974, been under local government control. Other board members with previous knowledge of the NHS tended to be hospital oriented. Some local authority members also saw themselves as spokesmen for particular interests. For instance, one local authority member of Beta insisted that a new boiler-house should be coal-fired rather than oil-fired. His preference for coal was not based on cost-effective grounds but simply because he represented a mining district.

The tendency for some board members to represent particular areas or interests was perhaps because in a state of general ignorance, members confined their attention, quite understandably, to the familiar, ie to places and/or ser-
vices about which they knew something. After all, board members receive no training or formal preparation for their tasks on health boards. It is simply a matter of learning 'on the job'. In connection with the 1974 re-organization, most new members on Alpha and Beta managed to attend a two day conference(42) at which officials from the SHHD, and from within the NHS, explained the structure of the NHS to members - how it worked, how it was financed, and where health boards and their members fitted into the structure. Depending on the arrival of new members onto a board and on the timing of these introductory gatherings, it was often a year or more before a new member was able to attend. Most members interviewed seemed to find the conferences interesting and informative but not of much direct help in enabling them to master their tasks. 'The preparation courses ... were worthwhile for background information but none of it was applicable to the working situation'. Another member's impression was more direct: 'It was a complete waste of time'. In short, as Heclo(43) concludes in his study of local councillors, the health board member's job, like that of the councillor, 'is one which is learned by doing, and there is little real effort to facilitate the process by advance preparation'. Consequently the job can depend heavily upon what a member makes of it.

A former health service administrator maintained that members could not really be prepared for their role. Preparation in the form of two day conferences was all that could be done. 'It's not easy. Working patterns have
to be worked out between members and officers in each board'. Nevertheless, a member of Alpha felt that more could be done to assist new members by, for example, running in-service courses. Perhaps the first six weeks of an appointment could be spent at a school where a member was fully prepared for his duties as a board member. The budgeting system in the NHS could be explained at length and members could be introduced to the different types of information they would be dealing with, and making use of, when arriving at decisions. Basic statistical skills could be imparted so that members became familiar with looking at columns of figures. They could be shown how to use the information and trends revealed by health statistics. New members (and some experienced ones who had yet to master their tasks) revealed in interviews that they had to resort to 'whispering, and asking, and running to someone and wondering what's this all about? Who do you run to? Another board? Or to the Secretary? They (ie members) may be afraid to seek assistance in case they reveal their ignorance'. The view expressed by one member probably summed up what the majority felt.

There is a difficulty in health matters in that so much of it is clinical, technical - the terminology used and the graphs and charts produced for us which, if we were honest with ourselves, would prompt us to ask where are we going, is this bad, is this good, is it to be altered and, if so, how? I find it extremely difficult to cope. We call for information and a lot of it is a little beyond our understanding.

Some members, referring to their past experience in the
NHS, claimed that it took two years or more really to begin to feel familiar with the area and services they supervised, and that by the time four years had elapsed one was gaining sufficient confidence and knowledge to make a more positive contribution. Unless a member was reappointed (and not all wished to be; nor was there any guarantee that they would be; nor might it be desirable that members were reappointed automatically if by doing so 'fresh blood' was denied to a board) for a further term, he/she could not capitalise on the experience gained from the initial induction period.

Unless a board member had a professional health care background (as in the case of doctors, dentists and nurses), or had had previous experience of health service administration, either from having served on the pre-1974 hospital boards or the local health authorities which existed prior to reorganisation, he/she was clearly at a disadvantage vis-à-vis other, more knowledgeable and/or experienced members.

Members were reluctant to divulge whether or not their board was divided into factions or whether some of them (ie those without a professional background) deferred to the professional members. However, the imbalance in abilities or expertise was not necessarily overt, resembling a crude 'them' and 'us' division between warring cliques. The imbalance was present in the very nature of the composition of the boards. For example, a medical member of Alpha admitted that he felt at an advantage over
the lay member (ie who had no professional expertise in health care), 'particularly those who have had no experience of the NHS. It must be extremely difficult for them to cope ... . The complexities of the NHS make it very difficult for an uninformed member to understand issues or to make an effective contribution'. This member did not believe that there was an obvious deference to professionals (particularly doctors) on the board, 'but they (ie lay members) tend to accept our word on medical matters and look to us for comments'.

A local authority member on Alpha felt strongly about this lay/professional division.

It is very difficult for board members to make an effective contribution. Because of your lack of professional qualifications you feel you may just be (or are made to feel that you are) talking a load of (rubbish). You begin to feel inferior .... This is where a board member has particular difficulty in beginning to argue with professional people. Although you want to pass an opinion ... , to give an outside opinion is not easy.

A member might have a view to express but along comes the professional and you think, well there's no point in the likes of me saying anything or else I'll get blinded with science .... There is a tendency for members to defer to the professionals once they've put their case. The probable doubts that could be in (members') minds are not expressed. Members feel inhibited to speak out. (44)

7.3 Organisation of Health Boards

In addition to the constraints which arose from the composition and functions of Alpha and Beta (and research carried out for the Royal Commission on the NHS suggests that many of these constraints have a much wider applica-
bility), other constraints were evident in the operation of the two health boards - the timetable of meetings; the frequency and duration of meetings; the existence and membership of standing committees, and so on. These, and other, structural elements could either facilitate or hinder attempts by board members to cope with the demands of their role.

The procedure adopted by Alpha was to meet in full each month (with the exception of either July or August - the holiday month), whereas Beta met every second month (ie six times a year). One reason for there being fewer meetings in Beta was the lack of business to justify holding monthly meetings. As the chairman commented, the problem 'is finding enough to do'. From replies to the questionnaire, both patterns of board meetings were typical of the patterns adopted by other boards. Of the ten health boards which completed the questionnaire, five held monthly board meetings (excluding either July or August, or both in two cases); three boards held meetings every two months; one board held meetings in April, May and every second month thereafter; and one board held a meeting every six weeks (ie four times a year). Interestingly, the pattern of meetings adopted by particular boards did not seem to bear any relationship to size. This did not apply to all the boards, but whereas the second smallest health board in population terms held monthly meetings, the largest health board in population terms held meetings every two months.
Attendance at board meetings in Alpha and Beta varied but was generally high. If a member does not attend over a period of six months or so, then the Secretary is empowered to discover the reasons for the prolonged absence.

Full board meetings are open to the public and the press, although, on occasion, a board will go into committee if business is being discussed which the board would rather conduct without the presence of the press or public. The system of standing committees is also a useful means of bypassing public scrutiny (see below). A few members suggested that 'people are a bit more restricted' when the press and public were present. One member said that because of the presence of the press at board meetings, he only asked questions which brought forth answers in favour of the decision being made, rather than provoke dissension among members. If he thought that the decision being made was incorrect then he would raise it at a committee meeting 'so that we can get a review (of it) or get it thrashed out without the inhibition of the press picking (it) up'. This member was wary of the press' news values.

There's no doubt about it - the fellow who complained about the food at a particular hospital, that's what went into the press; the fact that we were going to spend £2 million on something for the benefit of the community was not reported ... It makes you careful that when you raise something ... that you're asking for illumination (that is) favourable in the eyes of the press and ... in the eyes of the community.

The vice-chairman of Beta said that most of the work of the board was done at committee meetings, in part because
of the presence of the press at board meetings. 'Obviously you don't get into controversy - not if you're sensible anyway - or discuss critical situations, or make new decisions' when the press is present.

Very often board meetings were short, sometimes lasting for only half-an-hour. Most of the business involved ratifying the minutes of the standing committees. A press presence probably accounted in part for the short duration of meetings, since the bulk of discussion went on in the standing committees. Therefore, more important, perhaps, from a decision-making angle, than full board meetings were the standing committees which Alpha and Beta had established (see Diagram 5).

The philosophy behind health board committees had its origins in the Farquharson-Lang report which was directed at the pre-1974 hospital boards. It recommended 'that all boards should review their committee structure with a view to reducing the number of main standing committees to three or less, and to ensuring that any sub-committees ... are not set up to carry out tasks which could be better performed by officers'. The report suggested that 'house' committees should be dispensed with in any review of the committee structure (they no longer exist) since 'they encourage members to intervene in decisions of day-to-day management which we consider should be left to officers'. The type of committee structure which emerged in 1974 was part of the managerial style which infused the NHS reorganisation.
DIAGRAM 5  HEALTH BOARD COMMITTEE STRUCTURES

1 ALPHA

HEALTH BOARD

SERVICE COMMITTEES
(MEDICAL DENTAL PHARMACEUTICAL) PART MEMBERS PART PRACTITIONERS

POLICY AND RESOURCES COMMITTEE 12 BOARD MEMBERS

GENERAL PURPOSES COMMITTEE 12 BOARD MEMBERS

2 BETA

HEALTH BOARD

POLICY AND RESOURCES COMMITTEE 11 BOARD MEMBERS

HEALTH AND PERSONNEL COMMITTEE 12 BOARD MEMBERS

SERVICE COMMITTEES (MEDICAL DENTAL PHARMACEUTICAL) PART MEMBERS PART PRACTITIONERS

ENDOWMENTS SUB-COMMITTEE 7 BOARD MEMBERS

PART IV COMMITTEE 4 BOARD MEMBERS 3 PROFESSIONAL REPRESENTATIVES

SPECIAL PURPOSES COMMITTEE 4 BOARD MEMBERS
The guidance from the SHHD on committee structure envisaged a PRC and committees for Part IV Services (General Medical, General Dental and General Pharmaceutical). The former would undoubtedly become the largest committee in terms of numbers and, because of its remit (see below), would become the board's major committee. The idea was that 'Policy', embracing the planning of integrated services including priorities for capital programmes, and 'Resource Allocation', covering finance and staff, should be brought together into one committee in order to facilitate coordination. These developments were akin to those in local government reform.

Alpha and Beta had two main standing committees, in addition to which were a number of service committees, which dealt with technical and contractual matters such as conditions of service, and other committees set up for particular purposes. Of the two principal standing committees, the more important in terms of priority-setting and resource-allocation decisions was the Policy and Resources Committee (PRC). Of the ten boards which responded to the questionnaire, six had established a Policy (or Planning) and Resources Committee (one of which also had a Finance Committee, thus creating a hybrid structure which combined the related functions of finance and policy while at the same time separating them); three boards had a Finance (or Resources) Committee; and one board had both a Policy and Planning Committee and a Finance and General Purposes Committee (thus splitting the functions of policy and finance).
Alpha's second main standing committee was called the General Purposes Committee; Beta's was called the Health and Personnel Committee. From responses by the other ten health boards, seven of them had no second main standing committee (one had a sub-committee of its Policy and Resource Allocation Committee which covered personnel and finance); two boards had two main standing committees in addition to a PRC, covering establishment or manpower, and finance; and one board had a General Purposes Committee. All the health boards, including Alpha and Beta, had a variety of other statutory committees, and some had one or two committees for particular purposes. These usually met infrequently and were small. However, this brief review of committee structures has shown that Alpha and Beta's committee arrangements were, with the exception of their second main standing committee which few other boards possessed, typical of those adopted by most boards.

In both Alpha and Beta, the PRC's main tasks were to:

1. decide broad area policies and priorities in the light of information produced by the AEG;
2. approve budgets and short- and long-term plans before these were submitted to the Secretary of State;
3. approve the allocation of financial and manpower resources among services and districts within the area and to review the overall effectiveness of health provision;
4. review the performance and adequacy of services within the area in the light of reports from the AEG or from ad hoc committees of the board; and
5. take particular major decisions over and
above the routine (e.g., a hospital closure) and decisions specifically affecting the provision of services provided by matching local authorities or adjoining health boards. The second main standing committee in Alpha and Beta, although having different names, shared similar functions. The principal ones were to: (1) appoint senior officers and senior clinicians in accordance with procedures laid down nationally; (2) approve arrangements for training and recruitment of staff; (3) approve arrangements for dealing with staff appeals; and (4) approve arrangements for consultations with staff.

As the above list of functions clearly shows, of the two committees, the PRC was where members could, potentially, make a valuable contribution to decision-making. Whereas full board meetings could be cumbersome affairs, with twenty odd members present, plus the four chief officers, and other individuals in attendance by invitation, which occurred in the public gaze, meetings of the PRC were more intimate affairs where business was conducted well away from any public scrutiny. A member of Alpha saw the PRC as

a committee to iron out the lumps, bumps and kinks, advisory to the corporate board which meets to discuss what the PRC has broken down into its constituent parts. The PRC is not a decision-making body but it has broken the parts down so that the Board can then properly study its recommendations and agree or not agree. So the PRC has two bites at the cherry.

By the time proposals reached the board for approval, they would have already been thrashed out, or quietly accepted,
by the PRC. Board members were aware that the PRC was the most important component of a board's decision-making apparatus and that it was largely responsible for what was put up to, and finally passed by, the full board. In the words of Beta's vice-chairman, 'in practice the PRC is the more important (of the two committees), in theory no. One should be talking about money, the other about people. But you can do nothing without money'. Often, certain items would not go beyond the PRC unless a member wished to raise a matter at a board meeting.

The importance of the PRC in decision-making led to problems concerning the shape of committee structure a board should have, and the relationship of committees to the board. Powerful committees like the PRC added to feelings of isolation and remoteness among some of the board members who were not also members of these committees. As one member put it:

if you're not on the PRC, it's more difficult for a board member to put forward his view. You're at a disadvantage. The major decisions are taken in this committee - (it is) where priorities are (set), where the money is to be allocated. While it's true that these things come to the board in the form of a minute, people who're not on the PRC have got to have a strong point of view backed by local knowledge if they're to question the proposals in any serious way .... But there is a dilemma. Short of having everyone on the PRC I don't see any way round this (problem)... . The fact remains that if you're not on the PRC I don't think one is fully involved.

A vice-chairman thought that theoretically a powerful PRC did mean that members not on it were at a disadvantage vis-a-vis those who were but 'I don't think it worried anyone. (There was) a natural gravitation, depending on one's
interests, to either one committee or the other'. While there were sound reasons for establishing a PRC, one of the effects of having such a committee was to concentrate business in its hands and to limit discussion at full board meetings.

Alpha and Beta had different selection procedures for committee membership. In Alpha, the AEG put up names for a range of activities, including committees, for which members were required. The method was chosen by board members. The Secretary played an important part in the selection process for committees and this, inevitably, gave him some influence over their composition. 'All the names are in front of me. I knew a good number of them from working in (this area) before ... . For the PRC we wanted people of talent'. Board members were free to 'shoot down' the names put up but they had never done this. The Secretary believed that this was 'a better way of doing it' than other methods. There was 'nothing worse than saying we want members for this or that committee and looking round for someone to put their hand up. This is all a bit haphazard'. Normally, those with previous experience of the Health Service, or those with specialist knowledge that could be useful, were put forward as suitable candidates for membership of the PRC. New members, as a rule, were not appointed to this committee. They 'found their feet' on the General Purposes Committee. The Secretary said that

when members leave the health board who're on the PRC, new members go on to the General Pur-
poses Committee and members from there fill vacancies on the PRC. This is formalising even further the fact that one committee is much more important than the others. There is a lack of balance.

There was some cross-membership between the two main standing committees - six board members were on both, with twelve others on the PRC and twelve on the General Purposes Committee.

In Beta, selection for committee membership was undertaken by a Special Purposes Committee, comprising the chairman, vice-chairman, and the two conveners of the main standing committees. As the vice-chairman observed, 'there is no democracy about it'. Membership was decided on aptitude, although if someone expressed a preference for one committee rather than the other, then his/her wishes would be met if at all possible (this had happened on only two occasions). There had been, however, 'no cases of people clamouring to get on a committee they're not on. If they did, they'd be invited along'. The PRC had twelve members; the HPC had thirteen; and cross-membership was confined to the chairman, vice-chairman, and two conveners.

In both boards, the PRC met each month. In Alpha, the General Purposes Committee met every two months since there was not as much business to handle as there was in the PRC. In Beta, the HPC met every month, despite a general lack of business to occupy the committee. However, since the full board only met every second month, monthly meetings of both standing committees compensated for this, and served to keep members involved in the running of the
services in the area. (50)

A look at how the other ten health boards organised committee membership and the timings of meetings showed that Alpha and Beta were reasonably typical. In most cases, selection for committees was on the basis of either geography (ie to ensure that different parts of the area were represented), experience, background or expertise. In one board, selection was by votes; in other boards the wishes of board members were taken into account. Other criteria included spreading the work load and an ability to attend meetings.

In both Alpha and Beta, a second main standing committee was established to placate board members who were not on the PRC. Even if they had wanted to, not all board members could join the PRC. Had they been able to there would have been little justification for having such a committee, since it would have been no different from the full board. Therefore, some means had to be found to occupy the remaining members. Many felt a need to become more closely involved in the running of the Health Service than a brief monthly, or bi-monthly, board meeting allowed. As a Secretary put it, 'if you only hold one committee of the board, how do you satisfy members who don't serve on it? A PRC consisting of ten people and a board of nineteen - it becomes very invidious if nine are excluded'. And yet 'if you do it all through the board there'd be a long agenda'. The solution, therefore, was to have a second committee, although it was questionable how necessary this was beyond performing a symbolic role for members. Its only real value was in providing new members with an
opportunity to 'cut their teeth' before graduating to the more important work of the PRC. In Beta, officers felt quite strongly that a second committee was unnecessary since there was not the work available for it. One of these officers said,

I feel the HPC is unnecessary. It just deals with stuff that the PRC doesn't handle. (There is) not much for it to do. (It was) all right at the beginning when the structure was being set up and appointments were being made. But it is more difficult now ... . The agendas are usually small.

Often, officers were unsure how to divide business between the two committees and sometimes ended up by putting the same items to both. According to Beta's chairman,

we've had problems, in that, strictly speaking almost everything we do involves resources and therefore almost everything should go to that committee (ie PRC). It has been a problem on occasion finding sufficient work to justify a meeting of the (second committee) ... . There are occasions when we put items to both committees.

Having two committees meant that all board members were on one or other committee or, in a few cases, on both. For those who were not on both, they were kept informed of what was happening elsewhere through the circulation of agendas and background papers for meetings and through the receipt of minutes. In addition, a member was free to raise any matter at full board meetings. If the board felt strongly about a particular matter, then the problem would be returned to the appropriate committee for further consideration. Moreover, the system was flexible. As the Secretary of Alpha said, 'if a member raised a question who was not on the PRC but had a special interest in a
subject, then he can be coopted onto the committee.'

Nevertheless, while having two committees enabled all members to be accommodated in some kind of activity, as was pointed out earlier, the obvious imbalance between the committees in terms of importance did cause difficulties. This was inevitable when, in the words of one Secretary, 'the PRC is virtually the health board in all but name'.

There were two solutions to the problem. First, the status of the committees could have been equalised by removing finance from the PRC and handing this to the second committee. But there were sound reasons for resisting such a move. The Secretary of Alpha said that he wouldn't like to see a split in the functions of the PRC. Someone might say make it the Finance and General Purposes Committee (ie as in the case of one of the ten health boards), (but this) is an awkward break. A Finance and General Purposes Committee couldn't allocate resources, and it would mean passing it to the PRC to spend. If the PRC wanted more money, they'd have to go to the Finance and General Purposes Committee. This happened in the old RHBS. I'm trying really to make the PRC keep control of finance.

This was also the thrust of the Departmental guidance on the subject (see above).

A second solution would have been to abolish standing committees altogether (apart from the statutory service committees) and to arrange for business to be transferred to the full board. The AHAs in England and Wales are organised on this basis. Except for FPCs and a number of service committees, 'the AHA should avoid establishing standing committees of Members, with or without delegated powers, to deal with particular functions (such as finance)
... The AHA will itself take all the decisions on policy, planning and resource allocation ... '(51) But neither Alpha nor Beta had seriously contemplated such a move, although the Secretary of one of the boards admitted that there had been some discussion initially as to whether committees were necessary or not. 'What decided us in favour ... is that the board is open to the press. I don't want to sound secretive or authoritarian but there are (times) when you don't want the press there'. The other Secretary shared this view. 'If you just have a board meeting (with no committees), the press is present and people feel inhibited. A lot of discussion has to take place in a reasonably relaxed and free atmosphere'.

The committee structures of Alpha and Beta (particularly those aspects of relevance to the case study) have been explored in some detail since they were important elements in determining the extent to which a board member might be able to contribute to the development of the services in the area under his jurisdiction. It mattered a great deal which committee a member was on, since only the PRC was of real importance when it came to resource-allocation and priority-setting. This was where the 'spade-work' was done, and where 'the basic questions (concerning) the development of the service and the resources available (to do this)' were raised. As one board member put it, 'this is where the real meat of the decision-making process may be found'. Obviously much depended on the calibre of the members themselves - their personal qualities, experience, and enthusiasm for the task were all important factors.
But it is necessary to understand the structural framework within which board members performed their functions. For example, if a keen, active member was not, for whatever reason, a member of the PRC, then the opportunities open to him to enable him to make a positive contribution to the board's activities were somewhat diminished. It would be wrong to place too much stress on this since, as noted above, the system was flexible and could accommodate 'outsiders' (ie in the sense of board members not being on the PRC). However, as a further constraint operating on board members, particularly new ones, it is worth noting.

7.4 Demands on Health Board Members
The demands upon health board members are greater than those that were placed upon members of the former hospital boards. There are two straightforward explanations for this: (1) the responsibilities of members have expanded with integration, and members are now responsible for primary care services and community care services in addition to the hospital service; as one vice-chairman pointed out, 'board members have more to learn now - {they} have to get a much broader picture'; (2) there has been a sharp reduction in the number of lay people running the Health Service; in one board, for example (not Alpha or Beta), there are twenty-one lay members responsible for the services in the area whereas prior to reorganisation there were 159 lay members responsible for fewer services. One board member in Alpha felt strongly about her expanded role. 'I think it's beyond anyone's capacity really to
take an overall view. I'm not really happy about large areas - there are so many different aspects - we have to know about a vast range of services'.

The role of board chairman obviously differs from that of ordinary board members as well as carrying with it extra responsibilities. The chairmen of Alpha and Beta saw their functions in broadly similar terms but performed them slightly differently. Both took the view that it would be wrong for a chairman to interfere in the work of the officers who had to be left alone to run the services within the area. However, both saw themselves as more involved in administrative activity than ordinary members.

The chairman of Beta claimed that he was more than a board member - 'I'm kept in touch with disputes, crises, etc. I liaise with the officers. I'm over here (ie board offices) once or twice a week'. Both chairmen had offices located alongside those of the chief officers. The chairman of Alpha came into his office each day. 'I think it is important for someone like the chairman to be present. I like to think that I am a bridge between the board and the officers ... (I do not) interfere with the officers. I'm not looking over their shoulder whatsoever'.

In both boards it was the Secretary who fixed the agendas for board and committee meetings but the chairmen approved them and often suggested items for inclusion.

Apart from the personal qualities members possessed, what dictated the degree of involvement in health board affairs above all was the time at the disposal of members. Few
were in a position to give up infinite amounts of this precious commodity to health board business even if they had wanted to do so. The amount of time a member could spare for health board work to a large extent determined whether that member became heavily involved in board business or whether he remained on the periphery. Depending upon what a member made of his role, and how conscientious he was in performing it, it could be a time-consuming activity. Local authority members, for example, might express a deep interest in certain health care issues, but the time they could spare in order to pursue these interests in greater depth was strictly limited because of other commitments. In the words of one vice-chairman, 'local authority members are not much use'.

One member of Alpha thought that the complexities of the NHS made it difficult for those coming onto the board without previous experience and for those 'without time; I don't think it is so difficult for a lay member with time'. It was not possible to estimate with much accuracy the amount of time members spent on average each month on health board business because it varied considerably from member to member. Members were not required to spend a specific amount of time on board business. Farquharson-Lang\(^{52}\) produced some figures on time spent by BoM members on various duties, but these are unlikely to be applicable to health board members with different tasks. However, for what it is worth, the Farquharson-Lang report suggested that, on a monthly basis, the maximum amount of
time that members were expected to devote to duties should not exceed twelve hours. For smaller boards, the time expected should be well below the recommended limits.\(^{(53)}\)

At a minimum, there was the pure business side of the board - board meetings and committee meetings, all of which involved some homework in the form of reading background papers. Each member was on one or other of the two main standing committees, perhaps even both. Beyond these commitments, some members took on heavier workloads, including sitting on appointment committees, service committees, special sub-committees, like the Endowments Sub-committee, and programme planning groups\(^{(54)}\) In addition to various meetings, there were the numerous visits to institutions which occurred each month (see below), and the exercise of the public relations function outlined earlier. The demands on members' time could, therefore, be negligible or quite considerable. A member could perform his tasks with a minimum of advance preparation (ie simply glancing through papers the night before a meeting), or he could probe deeply into certain issues that interested him, or caught his attention. The vice-chairman of Beta suggested a possible breakdown of duties and the time taken up by each. The average board member would probably spend half a day each month on one of the main standing committees; half a day every second month on the board meeting; and 'I would think with special committees, appeals committees and interviewing or various visits, he should do an additional one to one-and-a-half days per month'. On average, a member would allow 1\(\frac{1}{2}\) days per
month for health board business. Beyond this, there would be the reading of minutes, reports, background papers, and so on. Of course, some members spent more time than others on board work, and this often depended on whether he/she was retired, and therefore had more time at his/her disposal, or whether he/she was a local authority member, for example, in which case the chances were that there was far less opportunity to become much involved in health board business. One member of Alpha, for example, spent four days a month on health board matters, including visits, reading through what would come up at meetings and making notes about things he did not understand. In addition, a certain amount of time had to be set aside for the social functions which always cropped up and which had to be attended. In terms of hours, this member estimated that he spent twenty each month on board commitments. Another member approached his duties rather differently. 'I don't spend a lot of time on health board matters', he said, 'I read what I'm given to read'.

7.5 Relationship between Health Board Members and Chief Officers

The atmosphere and operations of a board are determined to a large extent by the kind of relationship which exists between members and officers. Haywood(55)suggests that this is a problem in most public authorities but that in the case of the NHS it is exacerbated by the power of the doctors.

It is a very brave member who will challenge requests for additional consultant appointments or expensive technology or new acute units even
if it is realised that such developments often produce comparatively marginal improvements in health status and only continue to denude Cinderella services of resources.

Members of Alpha and Beta were reluctant to criticise officers or to disagree with the line they took on policy issues. In fact, most headed in the opposite direction and praised the officers on their efficiency and on their willingness to assist members with problems or queries. However, beneath this surface charm, there existed frictions and tensions.

In a setting where part-time lay board members, many of them with commitments elsewhere, were advised by teams of full-time professional managers, it happened naturally that officers, ostensibly the servants, became the masters. Members, inevitably, were heavily dependent on them for information, guidance and assistance. The relationship verged on the parasitic rather than the symbiotic. The vice-chairman of Beta said that 'accusations that all the health board is doing is rubber-stamping schemes evolved by the AEG (are) to some extent ... true'. After all, the officers know the needs, know the background, and the needs of their own staff. This happens mainly in development schemes. Unless a board member is prepared to do a lot of leg-work, visiting sites and talking to people, he's in no position to originate schemes himself, so the work will come to us from the AEG who in turn get it from the DEG. I take these statements at their face value.

The vice-chairman of Alpha expressed similar views.

Our function as a board is to discuss policy. We do this with the assistance of the executive
group (of officers) and 99.9% of the time we agree with and accept their advice because we are not knowledgeable enough to say that a particular scheme should have priority.

A member supported this view: 'clearly one is heavily dependent on the officers. You've got to be able to trust them and have confidence in them or else the structure can't work'. Another member conceded that 'of necessity, a board of part-time members has to be to a very large extent in the hands of officials who are experts and are well paid'.

This was the crux of the problem. The relationship between members and officers was not a conspiratorial one, with officers plotting and scheming behind members' backs and then ruthlessly pushing proposals through the various committees. The relationship existed as it did because of the structural imbalance between permanent officers and lay members. This is not to suggest that health boards are of no value (see below). As a medical member argued, the health board acts as an important check on officials and officialdom. But in the main the health board is a 'rubber-stamping' agency - it can't be anything else in the situation it is in. No fundamental changes of role are possible within the present structure. The problems (are) structural ...

Nevertheless, some board members maintained that the imbalance could be equalised if a number of changes were introduced. One chairman said, there was a tendency for us just to see things that they (ie the officers) had decided on and not always to see the things they had rejected. We weren't always terribly clear of their reasons for selecting (some) things and rejecting others. I have asked that in future we get more detail of the way in which the process
works out, particularly so far as objectives are concerned so that we have some knowledge of what these are.

A number of members wanted to see a greater range of options presented to them to enable them to reach a decision, as opposed to the board being a rather placid bystander to what often turned out to be a fait accompli. In the words of one member,

The AEG prepare papers for the board having talked it (ie the matter requiring a decision) out and having heard all sides of the argument, but there may have been a strong argument put up on the other side which board members might be tending towards but because they have not heard the other side of the argument (they) feel that the (experts) know best. You really haven't heard all sides of the argument (because) the papers arrive at one conclusion rather than present a range of options. Discussions within the (executive) groups are lost to board members. If, as a board member, you have reservations about the argument that's being put before you, you mask your reservations in temerity because you feel here is all the expertise saying this other thing and you don't know that there's been this other argument that supports your view. Or, maybe not having heard another argument, you're agreeing to what's there, (whereas) had you heard the other argument you might have been in favour of it. Papers present the ideal and an alternative (but) it's the ideal that's built up (and) the alternative which is without back-up. It's not entirely the fault of the executive group. We, as board members, don't ask enough (questions) concerning back-up information.

Haywood argues in favour of opening up decision-making and making options more explicit although he is well aware of the difficulties associated with it (eg slower decision-making, danger of information overload). He would like to see 'members and senior officers ... open up the conflicts inherent in the choice of local priorities and invite argument from interested parties rather than obscure
them by presenting a list of proposals as is so often done at the moment'.

Members might have had views about officers, but the latter also had thoughts concerning the former. These are described in the next chapter.

Despite feelings of frustration, dissatisfaction and occasional impotence, board members were united (not surprisingly) in their view that some form of lay input into the NHS administration was desirable and that it would be quite wrong to run the service with just officers accountable to the Secretary of State who, in turn, would be accountable to Parliament for the operation of the NHS in Scotland. According to one member

if you abolished health boards and left it to the officials I've no doubt that for the majority of cases for a majority of the time you wouldn't notice any difference. Whether it's a desirable practice in the long run is another matter. On balance, with something so close to people's needs as the NHS, I agree with the principle of lay involvement. There is no other serious alternative.

The vice-chairman of Beta said the board was essential in a purely practical sense. 'The AEG still needs somebody to hold the balance (ie to act as umpire or arbiter). If we weren't there, they'd have to invent a chief executive or a committee in (the Scottish Office)'. One of the chairman believed that 'there has to be an avenue where you pick up what is wrong with the Service ... Health board members have an outsider's "finger on the pulse" and I think there is a place for them, no matter how good the officers are'. 
7.6 Coping Strategies

Preceding sections have been concerned with various constraints which, in Haywood's words, 'help us to understand the gap between (members') prescribed and actual contribution to decision-making'. The discussion has also focused on some of the problems associated with the prescribed role and why it might be beyond the capabilities of most members. In this section, some of the ways in which members tried to make their role more meaningful are examined. Three areas have been selected for comment: (1) visits by members to hospitals, clinics and so on; (2) the specialisation of members into groups, each focusing on a particular functional area of health care; and (3) attempts to educate members and increase their knowledge and understanding of the NHS through lecture/seminar programmes. Each of these coping strategies is examined in turn.

(1) Visiting

Most members were enthusiastic about their visiting programmes to health service establishments (but see below). Visits served two purposes: (a) they kept members in touch with what was happening 'on the ground'; and (b) they provided members with a sense of involvement and usefulness, i.e., they served a valuable morale-boosting role. Most boards have a planned visiting policy. Alpha and Beta did as well as eight out of the ten boards that responded to the questionnaires. Although each board has devised its own visiting policy, sometimes in response to
demands from members, the origins of the approach adopted by most boards can be traced to the Farquharson-Lang report (58) which recommended that more time should be spent on visiting functions and somewhat less on meetings (hence the recommendation in the report to reduce the number of committees operating within the hospital service). 'Each board (ie RHBs and BoMs) should establish a planned visiting policy' with clear objectives.

The report (59) suggested three main objectives, two of which are relevant for the visiting programmes which have now been established by health boards. Visits were necessary, first, to acquaint members with the services within an area and to achieve personal contact between the board and the staff; and, second, to ascertain what effect had been given to the decisions of the board and to evaluate results. The third objective, to obtain the reactions of the 'consumer' through observation and consultation, is now the task of LHCs, although many board members continued to see it as theirs.

The chairman of Beta described his board's visiting programme.

The initiative for visits came from me, not board members .... We have a programme of visits every fortnight. The board is divided into groups of six people (ie three groups). Not all board members go every fortnight. I do. By the end of the year we all ought to have visited every hospital, clinic and unit. We visit laundries and boiler-houses, not just the wards.

The vice-chairman commented that the visiting programme, although a good system on paper, did not work so well in
practice.

If you set up a visit with five members to go to a hospital, you're lucky if three turn up. Usually two turn up and on occasion none has turned up ... (The visits were) almost entirely to hospitals, very seldom to health centres or other community services. In the present board (ie with a new chairman) we have a system of visits being set up (which) won't be the same as the last one. We're perhaps hoping to involve definite people in definite hospitals. It's an extension of the system under the old BoM in which the board was divided up into visiting representatives. You got to know the hospital and were the intermediary between it and the board. It was probably a good system for a BoM (but) not such a good system for a health board.... If you're making director decisions, you ought to know the whole situation.

The chairman of Alpha also placed great emphasis on his board's visiting programme.

What we've tried to do with members in the last two years is to make them familiar with the layout in (this area) and the units that are under our wing ... some take it up and some don't ... . It's a bit silly people making a decision about something and not having a clue as to what the place looks like ... . We've spent a lot of time making people familiar with the named units, so that the names mean something to them.

This visiting programme 'is not interfering in day-to-day management - it is an educational process and a getting-to-know process'. The board was broken down into small groups of three members and throughout the year each group went around all the units, visiting two or three each month.

Although many members, with the exception of medical members and others with a health care background for whom there was less need to familiarise themselves with the services within their area, found the visits invaluable,
it was easy for members to become over-involved in detail and matters of day-to-day management, and begin to press the interests of a particular ward or clinic at the expense of other wards or clinics that might have been suffering from similar deficiencies. As one of the board Secretaries said, 'visits are one way of keeping members in touch with what's happening without, I hope, getting terribly involved. The danger is that members will latch onto details on the visits, but it's a risk worth taking to keep members informed'. According to the chairman of Alpha, 'board members are there to educate themselves rather than to go around looking for faults. I would hope the staff would be aware of any faults or problems. They shouldn't come to board members'.

But there was evidence to suggest that members looked upon the visits rather differently. Whatever their educational value, visits were not undertaken primarily for this reason. The chairman of Beta again: 'board members felt they were going and seeing things but they weren't sure what sort of follow-up there might be. A sector administrator now accompanies members on visits and notes any points that arise'. A local councillor member of one of the boards valued the visits greatly because

in terms of policy implementation and follow-up, members are now in a position when they visit a hospital, etc, to see what is happening. Deficiencies can be highlighted. I was on a recent visit to hospital X and we found a great deal of concern (among staff) at certain deficiencies there. Naturally we're going to raise such matters.

The vice-chairman of Beta conceded that members on visits
were 'inclined to learn the bits (they) were walking about in'. They would pick on the deficiencies because this is what the local staff expected you to do. They took you to places where they wanted you to see something. The visit was an opportunity for staff to show board members things they (ie the staff) were complaining about. The tendency was to go back to the board and raise the matter there, whereas board members should have been scanning the picture as a whole and trying to see how it fitted into the general health board set-up.

Because LHCs were also expected to spend a great deal of time visiting those institutions being visited by board members, this caused some tension between the two sets of bodies. As the previous paragraphs illustrate, board members seemed to be becoming involved in the sorts of tasks (eg commenting upon standards, etc) that were, in theory, the preserve of LHCs. Many board members accused LHCs of duplicating their role and were reluctant to contemplate the possibility that Councils would begin to know more about hospitals, etc, in the area than they did. It was partly for such reasons that the Secretary of one of the two boards had still to be convinced of the necessity of visits. 'I suppose in this management structure one could say that this visiting programme is unnecessary. Board members are there to deal with policy matters; but I'm afraid the structure is not working out'.

In a sense, visiting programmes may be a throwback to past practices when BoM members were in and out of hospitals regularly, getting to know staff and taking up their problems with officers. However, health board visits (at any rate in Alpha and Beta) were not on the same scale.
According to one member,
planned visitations are vastly different from what they were in the hospital service where you had seven or eight hospitals to attend to. Now we've got numerous clinics and by the time we've been round the last one I'm quite sure one won't remember what the first was like.

Enough has been said to show that the visiting programmes could be quite a strenuous and time-consuming undertaking and, indeed, for many members this was the case, resulting in poor attendance at visits. An intensive visiting programme also made heavy demands on staff. As one member said, 'the personnel must be fed up with monthly visits from members'. In addition to visits from board members, there were the visits by LHCs. One board member thought that an arrangement would be necessary whereby LHCs undertook half the visits, and the health board the other half.

Possibly the chief benefit to be derived from visits was a psychological one. Board members felt 'needed' when they went on visits. They met staff and patients and were able to identify with the service directly. They could see for themselves areas where improvement would be desirable and all this contributed to a feeling of 'usefulness' on the part of board members. They believed that they were making a positive contribution to the development and improvement of services within their area. In the words of one member: 'Before the visits we were accepting the officials' estimate of the situation. After the visits you're a bit nearer to establishing the actual point of view of the staff'.
(2) **Specialisation**

Alpha and Beta were typical of most health boards (at least of those that responded to the questionnaire) in acknowledging that some members did show special interest in particular areas of health care, while encouraging them to take a broader view of the service. However, the responses from some boards showed interesting differences. Four health boards **encouraged** members to become interested in particular subjects like mental health, child health, health education, geriatric services and so on. In one board, members attended seminar courses and conferences covering these interests. Another board pointed out that members' interests depended upon their backgrounds. For example, trade union members were interested in staff/industrial relations; clinicians in technical health care matters; and councillors in their own district's health services. Special interests were encouraged 'because of the contribution which can be made to debate and decision'. Another board replied that 'it is important that members take an active interest in aspects of health care to perform their role effectively and add to the effectiveness of the Board as a whole'. In one board, special interests among members were encouraged 'within reason on the grounds that enthusiasm should be exploited. Appropriate committee authority is not jeopardised and the responsibility of senior officers is protected'. Only one board replied that there were no special interests among its members. The remaining five boards were not anxious to foster special interests among their members.
A few board members considered visits insufficient by themselves as a solution to the problem of lack of involvement in decision-making. They wanted to see boards split up into groups, each specialising in a particular area of health care, for example, geriatrics, mental health and so on. The proposed revamped visiting programme in Beta (see above) was a move towards greater specialisation. Moreover, the establishment of programme planning groups within boards represented a further step in this direction, although neither Alpha or Beta had set up sufficient groups to involve all members. It is not possible to say more about these programme planning groups since they were just getting under way when the research took place.

It has already been noted that reorganisation resulted in two, seemingly contradictory, developments. On the one hand, there has been an increase in the burdens placed on board members resulting from integration of the tripartite structure, while, on the other hand, there has been a sharp reduction in the number of lay people responsible for supervising this enlarged NHS. The previous section has shown that visits were not sufficient by themselves to enable board members to come to grips with the enormity of their task. This was why some members (albeit a minority) favoured splitting the boards up into small groups but still operating within a collective framework. They merely wanted to institutionalise, to formalise, and to make explicit a practice that was already occurring informally and implicitly. Other members were firmly
opposed to any form of specialisation in view of the 'danger of competitive factions if the board is divided into groups. A broad, overall view is essential for health boards'.

Members who favoured a degree of specialisation argued that the board would not revert to some kind of pre-1974 structure. The board would still operate as a cohesive, corporate unit (at least in as much as it did already).

'It's only a case of trying to make the task more manageable for members'. The vice-chairman of Alpha stressed that despite the fact that the service should be run as a whole,

I would rather be more knowledgeable of one section than less knowledgeable about the whole service. I feel one would be less dependent on the officers as the sole source of information since one would become an 'expert' in one's own area of interest. This idea was not enthusiastically received (by other members) since it was thought that it would defeat the whole purpose of the health board.

This tension between becoming a specialist or remaining a generalist posed a dilemma. A board member might be reluctant to specialise because if he did he might find himself unable to fulfil his role as a lay person taking a corporate view of the health services and health needs in his area. Yet if he did not specialise to some extent he also found it difficult to take a corporate view because he lacked sufficient knowledge of health care issues in the area, or even generally. Moreover, for a part-time voluntary member to be knowledgeable about the whole service and to perform a corporate role was practically
impossible, although it looked feasible on paper. Inevitably, therefore, members, perhaps even unthinkingly, specialised while maintaining a corporate facade. The areas members selected upon which to concentrate their efforts tended to reflect their backgrounds and experiences. According to one member

local authority members on boards already know about public health. People are always interested in the services in their own area because they possess some knowledge of these. People who come from hospital boards tend to know that sector quite well. Based on a combination of previous knowledge and interests you get people selecting - it's inevitable. It's true that from time to time there's a general overall view that involves everybody equally but for a lot of the time it's a question of pursuing your own interests.

Another member conveyed the ambivalence between the specialist and the generalist roles very neatly: 'you've got to cover everything. However, everyone has a particular bias in a certain direction'.

(3) Education

A final strategy adopted by Alpha and Beta to enable members to cope with their tasks was to increase their knowledge and understanding of the NHS by inviting people to come and speak to them. It was noted in a previous section that board members had to learn 'on the job'. The vice-chairman of Beta said that efforts were being made to understand the difficulties which faced members. One method of tackling these was the introduction of 'an elaborate system of teach-ins. At these, new members get to know the names. They get to know what a health centre is, and the size of particular hospitals, and what various
initials stand for'. The education of members was of particular concern to board chairmen. In Alpha, the chairman chatted to new members about their responsibilities. In addition, formal talks were arranged, undertaken by insiders and outsiders so that members were not only informed of the characteristics of their own board, but received some instruction concerning the NHS as a whole, including the activities of central bodies like the Common Services Agency and the Scottish Health Service Planning Council.

7.7 Comment
This chapter has focused on the role of board members in Alpha and Beta, drawing (where appropriate) on data obtained from other health boards in order to ascertain whether Alpha or Beta were typical or atypical of health board practices generally. Overall, they appeared to be typical. The chapter has also attempted to convey an impression of members' own perceptions of their role, and of how these related to official conceptions of it. Evidence suggests that there existed considerable uncertainty and 'mismatch' between prescribed practice and actual practice. Much of the responsibility for this lies with the appointment system. Nominees to health boards come from sectional interests and may be expected, perhaps occasionally, perhaps frequently, to push, or to ally themselves with, these interests. The dichotomy between, on the one hand, the official role of board members, and on the other hand, the backgrounds and experiences of those
who become members, has led to some confusion among board members concerning their purpose, or raison d'être. In Chapters 11 and 12, some of the constraints examined in this chapter reappear in a more specific context - the allocation of DF.

From the official literature one could be forgiven for thinking that health boards (the governing bodies) would be quite influential authorities. But the reality leads one to a different conclusion. Interviews with board members indicated strongly that perhaps the role designed for them is not one that can ever be adequately performed by part-time voluntary lay members (it is even doubtful if it could be performed by part-time voluntary non-laymen). It may be that the role requires re-thinking since the present demands upon members are, in many cases, not only beyond their capacity, but are also beyond their preferences. Moreover, what is irrefutable, is the imbalance which exists between the know-how of professional members and the relative ignorance of lay members, even allowing for the fact that the latter may possess useful skills. A similar imbalance is also evident in the relationship between lay members and permanent officers. What is more, in an attempt to overcome their ignorance, board members in Alpha and Beta were likely to lose sight of their prescribed role as they became more involved in detail and in day-to-day administrative concerns. This, in turn, placed them in a sensitive position vis-à-vis LHCs thus compounding their role confusion.
Reorganisation of the NHS has enhanced the status and influence of administrators in decision-making. Part of the change is revealed by wide usage of the term 'manager' to denote a significant shift in the role of officers. The distinction between management and administration is an important one. Emphasis on the former in the reorganised NHS is a fundamental element of the 'managerial style' described in Chapter 3.

There is a tendency in the literature on organisation theory to use management and administration as synonyms (the terms are also used interchangeably in the NHS). This is unfortunate since important distinctions become blurred. Clarification of the terms is essential if one is to understand more fully the nature of the change which has occurred in the prescribed role of officers, although in their day-to-day work they may continue to act as administrators rather than as managers.\(^1\) Keeling,\(^2\) in discussing the semantic issues involved in defining management and administration, claims that it is particularly confusing in the public service. Whereas in business the activity of administration is given a limited role as no more than a part of, and the inferior part of, management ... in the public service when administration has been differentiated from management it has tended to be regarded as the higher of the two activities - administration meaning policy advice and the making
of important decision rules, management meaning the implementation of the policy in accordance with decision rules.

Keeling advocates a usage for management in the public service consistent with its use in business, and his definition is appropriate as a description of the management tasks of officers in the NHS. Management, according to Keeling, may be defined as 'the search for the best use of resources in pursuit of objectives subject to change'.

This definition is closely related to one of the primary objectives of reorganisation, that of encouraging a better use of resources to provide improved health care. Administration, in Keeling's view, may be defined in similar terms to the accepted definition of management in the public service, that is, administration refers to the implementation of policy in accordance with decision rules. In short, the distinction between management and administration is that the former involves the taking of decisions on resource use (i.e., policy-making activity), while the latter involves the implementation of decisions, although there is some overlap between the two activities.

As was suggested in Chapter 4, the distinction may be broadened to incorporate the notion that management is about change to a greater extent than administration which is essentially about maintaining existing services in a state of equilibrium.

Sunderland suggests that management in the NHS can be viewed as operating at two levels. First, there is a policy and strategy level which seeks to ensure not only
that a service is provided, but that the optimum service is provided and that improvements are facilitated. Second, and complementary to the first, there is an institutional level at which the patient receives service. According to the distinction set out in the preceding paragraph, only the policy and strategy level qualifies for the definition of management; Sunderland's second level would come under the category of administration.

In the NHS officers combine certain managerial/administrative functions but the emphasis on the former since 1974 in the official literature is significant. Officers at area and district levels exercise greater managerial authority than sector administrators who perform administrative tasks although, as noted above, there is some overlap between management and administration. Many of the concepts and techniques introduced into the NHS in 1974, including delegation, monitoring, evaluation, setting objectives and strategic planning, all derive from the management function. An emphasis on management has also led to a situation whereby a considerable amount of decision-making activity lies with the officers with a minimum of lay supervision. Knowledge of what officers do, who they are, and the way in which they carry out their tasks is crucial to a fuller understanding of how resources are allocated, and priorities set, within health boards.

Officers operated at three levels in Alpha and Beta: there were the chief officers at area, district officers below them, and finally sector administrators for each sector within the districts (second-line officers were omitted
from the study). Diagram 6 illustrates the organisational structures for each of the management levels for the four principal officer functions - administrative, financial, medical and nursing.

Sunderland\(^{(7)}\) notes that

in considering the administrator who is involved in the policy and (political) arena, the focus is on the Area Administrators, District Administrators and their immediate support staff, since it is they who have had to respond to pressures on and in an NHS which has, for some time and increasingly in recent years, become the stage on which a wide variety of groups and organisations have demonstrated their political influence within the public sector.

Before examining the respective roles of area and district officers in Alpha and Beta and their respective management arrangements below districts, it should be noted that the description which follows of the officer structure in the two boards does not purport to be comprehensive. Rather it pinpoints key areas and major developments in the structure which appear to be significant in decision-making of the sort which forms the core of the case study. Chapters 11 and 12 take up some of the points raised here in the context of the allocation of DF.

8.1 Area Executive Group (AEG)

The discussion confines itself to the four chief officers, Secretary, Treasurer, CAMO and CANO, who collectively comprise the AEG in all health boards, including Alpha and Beta. Two other chief officers are often in attendance at AEG meetings, the Chief Administrative Dental Officer (CADO) and the Chief Administrative Pharmaceutical Officer
1 ADMINISTRATION

SECRETARY

- ADMINISTRATOR (PRIMARY CARE)
  - Administration of primary care services, including general practitioner contracts and certain secretariat work.

- AREA PERSONNEL OFFICER
  - Manpower planning, recruitment and selection, staff training and development, planned movement, staff reporting, staff establishments, implementation of Whitley Council agreements on pay and conditions of service, staff records, industrial relations, incentive schemes, staff health and safety, staff communications.

- ADMINISTRATOR (GENERAL SERVICES)
  - Management of support services provided on an area basis.

- PRESS AND PUBLICITY OFFICER
  - Supplies, the coordination of planning and works, secretariat work, etc.

- DISTRICT ADMINISTRATOR
  - Members of DEG, with corporate responsibility to the group and individual accountability to the secretary. Responsibilities include the organisation and administration of support services within the district.
  - Maintain close liaison with media.
  - Promote the board's aims, objectives, achievements and problems to staff and the community of the area.

2 FINANCE

TREASURER

- AREA MANAGEMENT ACCOUNTANT
  - Financial information and advice, assistance in budget preparation.

- FINANCIAL ACCOUNTANT

- CHIEF AUDITOR

- DISTRICT FINANCE OFFICER
  - Members of DEG, with corporate responsibility to the group and individual accountability to the treasurer.
NOTE: These 4 charts are representative of the departmental structures within Health Boards; they are not exactly those of either Alpha or Beta although both boards have similar structures.
(CAPO), but they are not part of the AEG's consensus decision-making apparatus. While the attendance of these officers at AEG meetings varies between boards, the CADO and CAPO only require to be present on occasions when matters concerning their particular specialisms are under discussion. Consequently, these officers occupy a 'twilight zone'. They are chief officers with management responsibilities and yet they are not members of the AEG although they can contribute to some of the discussions that take place within the Group. The exclusion of the CADO and CAPO from the AEG in all but an advisory role led, in one of the two boards observed, to some tension and friction among the chief officers. The CADO explained what, in his opinion, was wrong with the present arrangements. From the start, 'the dental profession, through the Dental Association, had a terrible struggle to get a senior administrative post of dentistry'. But it was only a partial victory since the CADO was denied full membership of the AEG. The CADO felt that the compromise in the long-term is not on because it produces a situation where one of the two prescribing professions is dependent on the goodwill (of the other), plus its own lower status, to get things done. The dental aspect has been regarded in most areas as an extra commitment that wasn't there before (reorganisation), and an expensive extra one.

The aim of the AEG concept is to move away from thinking about health care issues in narrow departmental terms. It represents an attempt to replace the former tripartite system of administration (medical, nursing and lay administration) with a health care management team. The creation of
AEGs is recognition of the fact that, in the words of one Secretary,

very few (issues) affect only one discipline ... In any one issue, one interest predominates, but all issues spill over into one another's preserve ... (All issues) affect all of us to a greater or lesser extent. I think this is the main strength of the executive group plus the fact that having decided something we've all got a joint responsibility to see it through.

Although the four members of the AEG are co-equals, the Secretary's role sets him apart from his three colleagues. Whereas the Treasurer, CAMO and CANO are all specialists in their respective fields, the Secretary is more of a 'generalist' and his skills lie chiefly in his ability to coordinate and to mediate between other members of the Group and between the Group and other bodies, ranging from the Board itself to District Executive Groups (DEGs) and professional advisory committees. These skills are essentially political ones, since the Secretary is frequently called upon to reach some kind of agreement on a matter among a diverse range of interests. Circular HSR (72) C3 states that 'the Secretary, as well as being responsible for the general coordination of the work of the executive groups, should have the particular responsibility for coordination in regard to the establishment of priorities and the allocation of resources'.(8) Inevitably, a Secretary's special responsibilities place him at the centre of a board's operations. Not only do these require him to be well informed about any particular situation, but his important coordinating role can become a controlling one in any particular set of circumstances. It
bestows on the Secretary the power to set the agenda for various meetings and, while the consequences of this may not mean much for most of the time, it is not a function shared by other chief officers. The differing views taken by Secretaries of their role reflected the personalities of the role occupants in Alpha and Beta. For example, one of them tended to play down his special duties and preferred not to set himself apart from the rest of the AEG, whereas the other Secretary took a different view, maintaining that 'somebody has to emerge as the chief executive within the Group'. In his opinion the Secretary was a primus inter pares figure. 'It's inevitable that it is the Secretary because he is the correspondent to the Board and the correspondent for the Executive Group'.

It was differences like these which accounted for variations in the manner in which the two AEGs operated. There were, in addition, structural differences. In Alpha, the AEG met each month, whereas in Beta the AEG met every fortnight (ie twice a month). Of the ten boards which responded to the questionnaire, the AEG in five of them met weekly, in three of them met monthly, and in two of them met twice a month. In addition, a few AEGs met informally at other times. Therefore, meetings of AEGs in most boards varied widely and the arrangements adopted were flexible to allow for changing circumstances within boards.

AEGs are free to decide for themselves whether to nominate
one of their members to act as chairman, whether to have a rotating chairman instead, or whether to do without a chairman altogether. Again, the practice adopted in Alpha and Beta differed. In Alpha, where the Secretary did not look upon himself as a chief executive, there was no fixed chairman, although the Secretary would often lead off a meeting/discussion. It was the Secretary's conviction that for any argument that crops up there tends to be one of us who has a major interest in it. There tends to be one predominating interest. Whoever has an interest under discussion he/she will take the leading role. This is instead of having a chairman or taking it in turns to be chairman. A problem with having a chairman is that he might become identified with that role and by virtue of this be given more authority - not in our eyes perhaps but by consultants and others.

In Beta, the AEG had a less flexible system. There was no rotating chairman, instead the Secretary acted as chairman at each meeting. Of the ten boards surveyed, none of them had appointed a chairman as such although most of them accepted the special status of the Secretary as Group coordinator. Only in one board did members of the AEG take it in turns to act as informal chairman. One board pointed out that although

strictly speaking the AEG does not have a Chairman ... in practice the role of the Secretary as co-ordinator is very close to that of a Chairman although of course he does not have the authority of a Chairman and can only operate within the consensus system and within the co-operation of his colleagues.

In other boards, the Secretary introduced items for discussion, sometimes guided the discussion and summed up.

In addition to his secretarial functions as the represent-
tive of the board, and his generalist (and political) functions as co-ordinator and facilitator, the Secretary also has line management responsibilities for a wide range of services, including management and support services (catering, domestic, transport, supplies, personnel and general clerical and secretarial services). When it comes to this set of functions, the Secretary is no longer a generalist but a chief officer with special interests to defend and fight for in the same way as the other three members of the Group. Performing these multiple roles can create problems. As one Secretary wrote in reply to a question in the survey, the Secretary's coordinating role at meetings of the AEG was 'a difficult role and detracts from his ability to take full part in discussion'. Yet, the Secretary's responsibility for particular areas of activity requires him to participate in discussions.

The role of Treasurer has undergone major changes as a result of reorganisation. Whereas the Secretary's present tasks remain basically unchanged, apart from greater emphasis on his coordinating and negotiating skills which are political in character, this is not the case with the Treasurer's functions. Circular HSR (72) C3(9) devotes a mere 2½ lines to the Treasurer's role which do not do justice to the profound changes which have occurred. These can be more readily perceived if one examines the proposals of the team of consultants who undertook to report on the organisation and staffing structure of health board Treasurer departments. (10) The
report was accepted by the SHHD after it was submitted in August 1973. It states that the main objective of re-organisation was to replace a fragmented management structure with an integrated executive organisation which recognises the complementary roles of medicine, nursing, community health, administration and finance in an effective group management team.\(^{11}\) In the Treasury function, the report continues, this implied a close and continuous involvement which had not been too apparent in the service up to the time of reorganisation. The Treasurer function required a change of emphasis from conventional financial recording, to financial management in its widest sense, applied positively and imaginatively to resource planning and control. The report stresses the need for the Treasurer to play a large and viable part in the management of the health services. This is to some extent a recognition of the low contribution a Treasurer often made. Since the Treasurer is an equal member of the AEG along with the other three officers, he plays an important part in the decision-making process. He is concerned with management accounting, linking resources to policies, and joins with his colleagues in the determination of the resources required to accomplish the objectives of the board.

The tone of the report resembles the rational actor model of decision-making, outlined in Chapter 4, and its preoccupation with management techniques, like management accounting, distracts attention from the essentially political considerations likely to be involved in any attempt to
alter the pattern of existing health services. Once again, this is a reflection of the management style which permeated the reorganisation of the NHS.

Treasurers now are, potentially, powerful figures. As one said, 'my function is 80% policy-making and 20% financial accounting'. Before reorganisation these percentages would have been reversed. It is the Treasurer's task to coordinate all available financial information and to disseminate it to all concerned. On these aspects of his role, one Treasurer remarked: 'I have to use my judgement as to the extent to which I am passing out all our financial information as an aid to management within all the different fields'. One of the CANOs argued that the Treasurer's role was a powerful one because either 'the money is there or it's not there ... ... At the end of the day finance has the final say'. However, one must be careful not to exaggerate the Treasurer's position. One of the Secretaries put it into perspective.

The financial role is essentially an advisory role. I don't think any Treasurer would claim that it is for him to decide policy. It's for him to show what resources are available, what are the principles of taking certain courses of action. That, as far as I see it, is the Treasurer's role ... ... Because he's on the executive group he has a hand in deciding policy. The Treasurer doesn't decide policy. He costs the options and presents them.

Again, it comes down to personalities as to whether, and how far, a Treasurer involves himself in policy-making, or whether he prefers to confine himself to supplying and commenting upon financial information as a means of assisting the other policy-makers.
HSR (72) C3(13) states that

the CAMO should be the chief medical adviser to the Board and should lead a team of specialists in community medicine in the identification of the health care needs of the population, the definition of medical objectives and the measurement of the extent to which these are being attained.

The CAMO's role is similar to that of his predecessor, the SAMO, who was a key member of the old RHBs. A major difference between the two is that CAMOs lead teams of Community Medicine Specialists (CMSs). Although in part replacing the Medical Officers of Health (MOHs), who were attached to Local Health Authorities before reorganisation, CMSs are a new breed of specialists. Reorganisation of the NHS laid great stress upon the development of Community Medicine and upon its contribution to the planning of integrated health services. It is the function of CMSs to investigate and assess the needs of the population so that priorities may be established for the promotion of health, the prevention of disease and the provision of medical care. CMSs advise CAMOs on priorities and health problems.(14)

Traditionally, doctors have had a rather ambivalent relationship with management,(15) and this is highlighted by the dilemma in which the CAMO is placed. On the one hand, clinicians detest management because they perceive it as a force that is opposed to the pursuit of good medical practice since it interferes with the sensitive nature of the doctor/patient relationship. On the other hand, if there is a problem, or if resources are urgently required,
then managers are approached since they control certain allocation procedures. Doctors concede that management is a factor in running the health service and that they must be part of it, even if they despise it, in order to safeguard their interests. The CAMO, therefore, is viewed with suspicion by his medical colleagues who think of him as a manager; but these same colleagues also look to the CAMO to fight for them and to win for them resources (money, manpower, equipment). As one CAMO acknowledged, 'I find I stick up for medicine and defend them (ie doctors) on occasion against the onslaughts of the others. That's presumably why I'm there'. Unlike his three colleagues, the CAMO is not in a line management relationship with other doctors. He has to operate by persuasion and negotiation. But these strategies are pursued by all chief officers whether or not they are in line management relationships since it is generally recognised that it is no longer possible (and certainly not wise) to coerce people into accepting a particular decision. In the CAMO's case, these uncertainties give rise to a degree of conflict between his role as a member of the medical profession and his role as an administrator.

Like the Treasurer, the CANO has had her (or his) status much improved, and her involvement in decision-making has greatly increased as a result of reorganisation (although the process whereby nurses were encouraged to acquire management skills began with the Salmon proposals in 1966). Whereas before 1974, Regional Nursing Officers
on RHBS were in advisory positions to the Secretary, Treasurer and SAMO (in much the same way as CADOs and CAPOs now are in advisory relationships vis-à-vis the AEG), CANOs are on an equal footing with their three colleagues on AEGs. As Wright\(^{(17)}\) has written, while 'all the health team professions will have a vital role to play in creating the new health system', ie an integrated NHS with an emphasis on prevention and care, 'nurses ..., by the nature of their role, would appear to be in a key position'.

One CANO, who was Chief Nursing Officer (CNO) at BoM level prior to reorganisation, compared his present role with his former role. As a CNO he had to work alongside a Medical Superintendent (abolished after reorganisation):

As CNO, it was very different because what Dr X (ie Medical Superintendent) did on the medical side was no concern of mine when it came to decision-making. It was a concern only when it involved nurses but there was no direct responsibility for what was happening on the medical side. The same (applied to) the administrative side of the hospitals. That wasn't my pitch either. But this job (ie CANO) I see differently because I think I've as much right as anybody else to criticise or comment on anything that's being done in any of the fields, just as they (ie other members of the AEG) quite rightly criticise or comment on anything I am suggesting for nursing. I don't see myself as just being involved with nursing ... it's very much wider and I think I'm working the job as was laid down for the AEG...

The other CANO looked upon his role in similar terms. 'Nurses', he claimed, 'feel that only since reorganisation have they really manoeuvred into a strong management position. On the whole I tend to be a member of the AEG first and the nursing member of the AEG second'. On occasion, like CAMOs, but to a lesser extent, CANOs experi-
ence conflict between being nurses and being managers responsible for the development of health services. One CANO cited an example which illustrated the kind of conflict that could arise. The example concerned overspending on the nursing budget at a long-stay hospital for patients suffering from mental disorders. The staffing ratios at the time were pitifully low as is often the case with hospitals of this type.

In a sense I wasn't surprised at the overspending. I was in some ways sympathetic towards it. But at the end of the day I obviously had to decide which was the right course of action. I didn't find it particularly difficult to take an administrative point of view and say, 'I'm sorry, (you are) overspent; you shouldn't have done it because you place us (ie the AEG) and the DEG in an invidious position; you make us bad managers and we can't tolerate that.

The CANO maintained that acting in this way was, 'part of the pressure to be seen to be good administrators so we will be accepted as such'. The CANO was looked upon as a manager by nurses. 'I think this crops up most often when they want some goods you can't deliver. On the whole I am considered an administrator who in some ways has sold out to nursing by becoming an administrator'. The other CANO did not appear to experience any tension between his role as an administrator and his role as a nurse. 'I look upon my role very much as being for the good of the patient ...I can get things done whereas as a charge nurse when I wanted things I was dependent on others fighting for them on my behalf. I can get changes made now, although it may take time'.

The CADO and CAPO, as noted above, are not members of the
AEG, their relationship to it being an advisory one. Circular HSR (72) C3 states that 'the CADO and the CAPO should have the right to attend meetings of the executive group on the same terms as members when matters concerning dentistry and pharmacy are discussed'. The fact that one of the CADOs was unhappy about his status in the AEG may have been nothing other than a reflection of particular personality traits. On the other hand, it is possible that the structural composition of the AEG, and the CADO and CAPO's peripheral involvement, gives rise to genuine grievances. In the competition for resources, the CADO and CAPO are at a disadvantage if members of the AEG decide to reach a consensus on an issue which excludes either officer from any further say, regardless of whether or not they agree with the decision reached. One CAPO claimed that both he and the CADO were in an impossible position - they were neither of, nor were they apart from, the AEG. They were suspended in limbo between their administrative roles and their professional specialisms, and both found it extremely difficult to become fully involved in AEG business when so much of it was not of direct concern to them. One CADO claimed that when priorities were under discussion they were sorted out in his absence. Invariably, dentistry suffered since the specialty was 'not sufficiently well understood for four non-dentists to assess the priority of a dental priority without face-to-face discussion in depth'. The CADO maintained that at the root of it all was

a status problem. The situation is such at present that any dental development won't get off the ground because (there is) no dental
voice strong enough to come in on the priorities. To start off in a new post (ie as CADO) with one hand tied behind your back and one foot tied to another foot is a little more of a handicap than is fair.

Chief Officers and Health Board Members

A great deal of the time of chief officers in Alpha and Beta was taken up with health board meetings and with the meetings of standing committees, the heaviest burden being borne by Secretaries. It was normal practice for all members of the AEG (CADOs and CAPOs and other personnel attended when items of relevance were being discussed) to be present at all these meetings. In the last chapter, the relationship between chief officers and board members was described from the perspective of the members. Officers also held opinions about this relationship and it is worth considering these. Like board members, many officers were reluctant to divulge their views on this subject but it is possible to say something about the relationship as perceived by them.

Officers were equivocal in their opinion of board members. Although critical of them, they did not think that they were unnecessary. While officers could be sceptical of the value of board members they accepted the need for some form of lay input in health service management and decision-making. One Treasurer's views were reasonably typical of what officers generally thought of board members:

One must have public participation in such exercises (ie health service management) but my experience to date both of RHBs and health boards would tend to suggest that health board members find it very difficult to appreciate a total problem. They tend to look at
isolated problems and discuss these fully because they understand them and know of them. It may be that we don't give correct information to the members. On the facts that I have it is easier to get through (the board) a large chunk of expenditure than it is to get through a few hundred pounds. Are members educated properly into providing the sort of function they should be providing? Are members given the knowledge which would enable them to ask the correct questions? They are required to monitor us. They are required to take policy decisions. Are they educated to take policy decisions? Do they know how to? They get no education ... to enable them to take a decision. They learn as they go along. Perhaps we're not teaching them properly. You can't give members too much information or they become swamped. But you have to give them enough information to look at the whole problem .... It's a difficult problem. I don't know if we as officers are enabling members to exercise their prerogative.

On the strength of these views one could argue that health board members are unnecessary since they fulfil no useful purpose. But the Secretary of Alpha said:

I've often thought this and I think I'm bound to say that although all these nationalised industries like gas, electricity and so on appear to run themselves without members, I think members at times have a humanising effect. They are a check against bureaucracy and perhaps on that basis they're useful.

It would appear, then, that although officers valued board members in a broad sense as being in a position to exercise some form of accountability to the public for the way in which the NHS is run, they did not look upon members as being in a position to exert much influence on decision-making within boards.

8.2 District Executive Group (DEG)

The same principles apply to the formation of the DEG as
to the AEG. A DEG comprises a District Administrator (DA), a District Finance Officer (DFO), a District Medical Officer (DMO) and a District Nursing Officer (DNO). It therefore mirrors the composition of area groups. When dental or pharmaceutical matters are discussed by DEGs, the officers concerned attend meetings of the Groups in the same way as their area counterparts attend AEG meetings. In addition, other personnel, like the Chairman of the district medical advisory committee (if one exists), attend meetings when invited. DEGs in most health boards meet formally once or twice per month plus additional informal meetings.

The function of the DEG is to provide health care to patients including all necessary support services which patients and staff require. Because of its location close to the point of service delivery (although still too remote in the opinion of some critics of reorganisation) this makes the DEG an important source of information and advice about current deficiencies and future service needs. Circular HSR (72)C3 states that 'the DEG should cooperate with the AEG in the preparation of plans and budgets'. Each DEG is 'responsible for the administration of integrated primary care, hospital services and community services'. Control over district management is exercised by means of approved plans and financial budgets. The district executive has autonomy in those areas which do not conflict with area policy.

The relationship between DEGs and AEGs is considered later. First, there follows a description of the struc-
ture and operation of DEGs from the perspective of the district officers themselves. As with the description of AEGs this is not a comprehensive picture of how DEGs operate, since this is not the purpose of the case study. Rather the description focuses upon those aspects which require elucidation if the decision-making process in health boards is to be more fully understood.

Of the four members of a DEG, the DNO has perhaps had the least adjustment to make. The posts of DA and DFO are new. Whereas under the former BoM structure the administrative and financial functions were combined in one post - Secretary and Treasurer - these functions have now been separated. The main reason for such a move arose from a feeling that financial considerations had tended to be neglected in decision-making. The Secretary and Treasurer post was invariably occupied by an officer with a leaning towards administration rather than finance, the latter usually being the responsibility of the Deputy Secretary and Treasurer. The change has not altered the DA's administrative tasks, and it is the DFO whose status has been enhanced. The financial function has been strengthened at district level in the same way as it has been at area level, which reflects the concern of the architects of reorganisation in regard to the use of resources. The emphasis on financial control is an attempt to improve the efficiency of the service through optimum use of resources.

The DMO's function has not changed to the same extent as
the background and expertise of the role occupant. There are now no Medical Superintendents, the prima donnas who wielded considerable influence in the hospital service at BoM level. The DMOs are all former MOHs with the result that their expertise and experience are derived from community services and preventive health care. Their interests lie primarily in these areas, with the consequence that their knowledge of, and enthusiasm for, hospital care (particularly acute care) may be negligible. A DMO in Beta wrote:

(22) as a DMO and a medical manager it follows automatically that I am a member of the community medicine team. The purpose of that team is to achieve in the long-term the unification of health care services, inside and outside hospitals, for the benefit of the total community .... The growing public belief that top quality health care is confined to hospitals and that the hospital service deserves top priority must be opposed .... The need for admission to hospital often arises out of the failure to develop to the full other health service components. These components include services to prevent illness and to provide care, rehabilitation or support in the health centre, the school, the workplace or the home .... The hospital .. must not be seen as a monument to those who conceive it or plan it or who work in it .... (It) is but one component in a scheme of total health care ....

Former MOHs were employed by local authorities, therefore the organisational setting in which they operated before their abolition in 1974 was vastly different from the NHS organisational structure. In Alpha and Beta, the fact that the DMOs came from such a background affected relationships between DMOs and hospital staff, particularly consultants, and probably accounted for some of the bypass-
ing of the DEGs which took place (see below), but it also affected the operation of the DEGs and the flow of power/influence within the Groups. Unlike a CAMO, who was more likely to be favourably disposed towards the hospital service (especially if he was a former Medical Superintendent), a DMO was less likely to see health priorities as residing there (the quotation above from a DMO confirms this). Most DMOs were concerned primarily at the neglect of preventive services. For example, one had a particular desire to introduce a hypertension screening programme. Moreover, for some, the transition to consensus management had been less than smooth. As one DMO asserted, authority was more diffuse in the NHS whereas in local government there were chief executives.

In view of what has just been said, it was hardly surprising that some DMOs were not entirely happy with their new function. Indeed, a few (as they revealed in interviews) found adjustment to their tasks quite traumatic. One suggested that perhaps local authorities were better at providing preventive services under the MOH structure since these services were an MOH's sole concern. Now, a DMO was involved with hospital services, community services and primary care services. In their review of the impact of reorganisation after the first year, Lewis and Weiner(23) observed that an MOH background for the role of District Community Physician in England was usually seen as not very prestigious by hospital-oriented team members, especially clinicians, who often looked upon MOHs as 'failed doctors. Their (ie DCPs) chance of being effective in
the hospital setting is therefore small'.

In this setting, where the DMO is a new figure to NHS management, the lay administrator (ie the DA) is potentially in a strong position. Like the Secretary at area, the DA has the task of coordinating the activities of the DEG, and, again following practice in the AEG, he normally initiates discussion and guides it, conveying the DEG's views to the AEG, and its decisions to the sectors within the district. The DA normally comes from a hospital background (the DFO likewise) and, therefore, the chances are that he will know more about medical problems in hospitals than the DMO, although imbalances of this kind will probably level out as DMOs familiarise themselves with the hospital service. However, because most DMOs are not especially interested in hospitals, since most of their working lives have been spent trying to shift the emphasis in health care away from acute hospital care, DAs may be expected, in some cases, to retain their initial advantage. At the same time, DMOs have come to appreciate the voracity of hospitals in their consumption of resources, and the persistent pressures coming from them for more resources. Paradoxically, despite DMOs' commitment to community care and prevention, their weakness vis-à-vis the hospital service, and their ignorance of this sector, could seriously hinder their ability to bring about the desired shift in priorities. In an attempt to win favour with hospital consultants, among others, DMOs may go out of their way to appease them by channelling resources in their direction or, at the very least, fail to oppose vigorously proposed
developments in that sector. The field work did not provide conclusive evidence to support these speculations but the weak, rather tenuous, position of DMOs was clearly apparent.

In some DEGs the DNO also comes from a community care setting (eg district nursing), and in those DEGs in Alpha and Beta where this was the case, the officers were evenly divided along hospital/community lines (ie a 2 + 2 configuration as opposed to a 3 + 1 configuration). The cross-fertilisation of experiences and expertise appeared to be a positive force in DEGs, particularly where a balance existed between hospital and community interests. One DFO, for example, confessed that 'at one time ... if anything came up from the community I just thought it was a waste of time - I enjoyed the hospital side. I think we're all changing now and looking at both sides'. The shift in thinking was certainly assisted by the SHHD memorandum(25) on priorities in health which emphasised the need to give priority to community care and to hospital services for the long-stay chronically sick. The fact that national priorities are now similar to those expressed by DMOs, and some DNOs (and others), may serve to bolster their status in DEGs. It certainly makes it far more likely that DAs and DFOs will be sympathetic to the views of DMOs. However, it is important not to ignore the very real constraints which hinder attempts to pursue different priorities. (27)

Perhaps the most significant feature of district officers is their line management relationships with their counter-
parts at area - 'officers who are members of the DEG should be responsible to the chief area officer of their profession'. However, line management could be a source of tension between districts and areas. It was noted in Chapter 3 that the relationship between these tiers is more clearly defined than the previous relationship between RHBs and BoMs. Moreover, it is a different relationship (some would argue a more constricting one) from that adopted in England between AHAs and DMTs.

In Alpha and Beta, problems surrounding the line relationship centred on the status of the DEG. Some district officers were of the opinion that a superior/subordinate relationship weakened their position vis-à-vis service providers, particularly clinicians, who might be tempted (and sometimes were) to bypass the DEG and 'go to the top' (ie the AEG). There were also complaints from district officers about frequent area interference in district affairs. One DNO thought that the districts lacked autonomy and that the relationship between his district and the area was unsatisfactory.

It's not a running battle with the AEG. There's a vagueness. It might have been better if there had not been a direct line relationship, but instead areas functioning as the old RHBs did, like advisory bodies which allocated the lump sums every year intact. If the area had been a broad policy decider, the district could have implemented decisions.

It was pointed out in Chapter 3 that, in theory, the area's role is that of broad policy-making, while the district has an executive function. But in practice, the functions become blurred (see below).
The most important aspect of line management concerned the functioning of the DEG itself as a consensus team. Line management could put a strain on this. In a particular situation where a district officer was being pulled in one direction by his group (ie the DEG), and in another direction by his superior at area, did he remain loyal to the group of which he was a member, or did he remain loyal to his superior? Clearly there was a dilemma here, and while the case study did not encounter any occasions where this conflict of interests had to be put to the test, officers at district were convinced that it would only be a matter of time before their divided loyalties were put to the test. It is a catch-22 situation, because, when that happens, whatever an officer decided to do would probably lead to serious damage, either to the functioning of the DEG or to relationships between areas and districts.

If problems were to arise and loyalties were to be tried, then, according to one DFO, money, or rather lack of it, would be the catalyst. Resource constraints could lead to severe strains being placed upon the consensus concept and upon the operation of teams.

In some of the other things where we've not always agreed with each other money hasn't come into it - it's a matter of principle or something like that. So it's easier to reach a consensus agreement then. I don't see how it'll happen in the future. When money is tight it puts a strain on the consensus concept. I may be wrong. But I warned my colleagues the other day that this might happen.

The DFO felt so strongly about this that he said he might have to dissociate himself from DEG decisions over expendi-
ture because of the restrictions governing recruitment of staff. He would have to register his dissent at the DEG, have this recorded in the Minutes, and let the AEG examine the matter. He would also work closely with the Treasurer, if necessary against the DEG. The DFO gave an example of the kind of situation that could easily arise. This concerned funds the DEG had set aside for the recruitment of paramedical staff which had remained unspent because staff were unavailable. However, if staff were to become available and moves were made to fill vacancies, the DFO was adamant that he would oppose funds being used for this purpose on the grounds that if a department had managed without additional staff for so long then perhaps further increases in staffing were unnecessary. Faced with this situation, the DEG might feel that the needs of the service were more important than purely financial considerations, but the latter were clearly of paramount importance to the DFO.

In the questionnaire, health boards were asked to comment on the line management relationship and the difference between the Scottish and English arrangements. Of the ten boards which responded, six were multi-district areas and all of them (perhaps not surprisingly since, in most cases, the questionnaire was completed by board Secretaries) expressed a clear preference for the line management relationship. Several respondents showed an awareness of criticisms which have been made of the English system and referred to the 'unwieldy and time consuming' nature of it 'in respect of decision-making'. As one administrator
put it, 'I ... would think (the English system) even more difficult than the Scottish one, and that is saying something'. Most respondents favoured line management for (1) its clear lines of responsibility/command, (2) its greater certainty, and (3) its unified advice on policies. But one administrator conceded that line management would be difficult to apply in England because of 'the length of the management chain from the region down to sector', which 'would make a through line comparable to Scotland to be so long as to become unworkable'.

The structure of the DEG (consensus management is considered separately in the next section) having been described and some of the more significant and, for present purposes, pertinent features highlighted, two other areas remain to be examined: (1) the relationship between districts within Alpha and Beta, and (2) the relationship between districts and area within each board.

There was an element of competitiveness in the relationship between the DEGs in Alpha and Beta. A DA in Alpha commented:

> While each DEG should have regard to the overall needs of the area, in fairness to the staff working within each district, we've got to do the best for them. Sometimes that can involve a competitive attitude - you've got to argue the case as best you can. You might, at the end of the day, see the other point of view and withdraw, but it's like playing a sport: once you've put on the jersey you've got to play as hard as you can for the team.

The other DA claimed: 'What I'm doing is in the best interests of (this) district ... I would bend (the rules and regulations) as far as I possibly could to get what I
think is needed done'. In Beta a similar competitive posture was adopted by both DEGs.

While competition could create tension between districts anxiously awaiting more resources, other factors contributed tension to the relationship between districts. For example, in both Alpha and Beta, the board headquarters were located within one of the districts not far from that district's offices. Contact between the area officers and those district officers who worked close by was more frequent and more pervasive than contact between the area officers and the district officers in the adjoining district (which in each case was about fifteen miles from the board headquarters). According to a DNO in Beta who worked in the district furthest away from the area offices, 'the other DEG has a different relationship with the AEG than we do. They're in and out all day long. I suspect it's a very different relationship. I prefer a distance'. Area and district officers working in close proximity frequently met at lunch (at the same hospital canteen). It is not being suggested here that this close, informal contact reflected itself in decisions which favoured one district rather than the other. While this may occur, the field work did not discover such influences at work. But it is fair to state that the relationships between both districts with the areas in Alpha and Beta were not equal; nor were they perceived to be by district officers. And it seems fair to conclude that although there are arguments to support the view that districts are able to function better at a distance from the board headquarters (and some of
these were cited by district officers in that position, ie an increase in feelings of independence; a useful means of avoiding close scrutiny, etc), the suspicion is always there in the minds of those officers who are unable to share such a close relationship that perhaps favouritism could occur, however imperceptibly. After all, in an environment where much business is carried out informally during casual encounters this would seem a perfectly reasonable assumption to make.

The districts in both boards were unequal in another sense, namely, two (one in each board) were better endowed than the others in terms of resources and service facilities, and had higher standards of service provision. These inequalities were inherited from the previous structure, and appeared to increase the competitive element between districts, leading to a certain amount of envy in those districts which had inherited what were alleged to be 'substandard' facilities. In this situation it was the task of the AEG (or one of its tasks) to remove, or at the very least to ameliorate, these imbalances which were a source of discontent, preventing the attainment of an equal standard of service throughout an area.

More significant perhaps than the precise geographical location of district offices in relation to health board headquarters, or the varying levels of service provision within districts, was the vulnerability of the districts within Alpha and Beta. As mentioned in Chapter 3, the formation of districts was guided by a number of criteria,
one of which was population, i.e., ideally a district should have a population of around 200,000 in order to form a viable unit. But three out of the four districts which comprised the two health boards had populations considerably below this figure. Another criterion governing the creation of districts was management considerations. Circular HSR(73)C7 states:

> a district organisation may be justified where the service is so complex that the officers comprising the AEG would have insufficient time to devote to the management as well as policy problems, to know and liaise sufficiently well with key medical and other staff at operational level in both the health and community services or keep in touch with professional advisory structures.

It was debatable whether Alpha or Beta did present managerial problems which could not be overcome without districts (i.e., become single-district areas). Unfortunately, both boards fell into the category of borderline cases. However, in the discussions which took place in the two boards to decide whether or not districts were necessary, there was a strong feeling among chief officers that they were unnecessary. As a result the districts did not feel particularly secure, knowing that at area level their existence was not unanimously accepted. It seems that a decision finally to divide both areas into districts was taken partly on geographical grounds - both boards had large expanses of rural areas - and because of the existence of local government districts. Feelings of vulnerability ran especially high in the districts in Beta where the chief officers made no secret of the fact that they would have preferred to operate a single-district area. In single-district areas, accord-
ing to the circular, (31) AGBs perform a dual role: 

on the one hand (they will have area type responsibilities including involvement in policy preparation and planning and, on the other, (they) will have to carry out the district officer function of ensuring the efficient organisation and day-to-day running of services.

In theory, districts make sense, as responses to the questionnaire revealed. For example, districts enabled administration and policy decisions to be decentralised; they enabled a differentiation to be made between the daily running of the service and major policy and planning; and, finally, they obviated the need for senior officers to spend time on minor matters. A district structure, according to another respondent, also facilitated 'closer contact with the public'. More realistically, perhaps, a third respondent replied that while

theoretically the advantages of having districts are that area staff can concentrate on strategic planning and resource allocation leaving district staff to concentrate on day-to-day management and health care ... much depends on the abilities and personalities of staff at both levels.

For several boards, including Beta (see below), districts created problems. For instance, according to one board 'control of budgets is difficult as finance officers identify with their district not with area control' (as noted above, this did not happen in all cases); moreover, 'competition between districts is a problem (as noted above) in an urban situation where population crosses district boundaries for hospital services and (where) duplication of many specialties is too frequent'.
By comparison, single-district areas were simpler to administer; the structure was less complicated; and overlap and duplication of functions were eliminated. Responses to the questionnaire from administrators in single-district areas bore out these views. It was suggested by one board that the advantage of a single-district area 'lies in the avoidance of confusion as to the responsibilities of AEG/DEG where these tend to overlap'. As the discussion below reveals, the problem of overlap was apparent in Alpha and Beta. For another board, the main advantage of single-district areas 'is the direct link between Board and user without additional tiers, (and) consultative processes are less cumbersome'. However, two of the health boards with single-districts pointed to two disadvantages with their structure: (1) because a management tier was missing, this imposed a heavier load on AEG members with no supporting staff to compensate; and (2) having no districts led to the involvement of area officers in local and minor issues.

As already mentioned, district officers in Alpha and Beta were well aware of the opinions area officers shared in regard to districts. It did not make their task any easier, having to operate in an insecure environment where they lacked the support which they expected from their superiors at area. 'The consequence', writes Sunderland,\(^{32}\) 'is conflict, whereas the system assumes cooperation'. It is necessary to stress that for the most part these underlying tensions were not clearly dis-
cernible. They emerged from 'off-the-cuff' remarks made during interviews; on the surface, the relationship between the areas and districts was quite amicable, which was perhaps unusual in Beta where the underlying tensions were more profound.

In particular, the drawing up of appropriate demarcation lines between tiers proved troublesome. The principal grievance DEGs had in Alpha and Beta concerning their relationship with their respective AEGs was that the latter could bypass them. Bypassing has already been mentioned in the context of professionals delivering services who were occasionally tempted to refer a matter to a chief officer (normally doctors going direct to the CAMO) instead of working through the appropriate district officer. This might be termed 'bottom-up' bypassing and was a symptom (1) of the weakness of the district concept in the eyes of many professionals, especially consultants, and (2) of their reluctance to give up practices which had been learned under the former NHS structure in which quite senior officers with greater autonomy and status than district officers were easily accessible. 'Top-down' bypassing also occurred, manifesting itself in interference by second-line area officers in district matters without consulting district officers or delegating the tasks to them. A DA expressed the problem in the following terms:

I would see this DEG as being the voice of the users. If the area wants the views of the users, it should come here and get them. We would go down the line and gather the views. We're not working this way at the moment. The area tends to be going direct to some of the
users themselves especially on the medical network. I don't think this is the right way to work. (It) has been going on since the beginning (of the new service). I'm beginning to think that it is deliberate. Whatever comes out of this we as a DEG will have to administer it and run it, therefore surely our views should be sought ... (The area) doesn't need to go along with our views but I think we should be asked. I think the users have a right to be heard. It should come through us, not by asking this consultant or that. At present the district is being bypassed.

The DA argued that if there was a great deal of direct contact between, say, the CAMO and consultants then this could lead to distortions in the decision-making process which would endanger the entire point of the structure. 'Individuals ride "hobby-horses". It is the job of the DEG to assess these views. We can qualify individuals' views when sending these to the AEG. The district is in a better position to do this than the area'. A DFO in Alpha argued that area interference in district affairs might stem from the cumbersome nature of a two-district structure in a small area. 'It may be that the area people don't have enough to do at times and they get involved in things that are not quite their concern'.

Certainly, it seems likely that the bypassing, whether of the bottom-up variety or the top-down, of DEGs is more likely to occur in small areas. Alpha and Beta were susceptible to it on account of their medium size. But other factors were important too. For instance, in the words of one DA, the relationship between his DEG and the AEG was the result of 'not enough talking' between them.

In the opinion of a District Community Physician working
for an English AHA, the chief problem with multi-tier consensus management is 'the risk that the tiers will not themselves recognise the part that they are supposed to play and will try and take over each other's roles, either through lack of clear thinking or a wish to assert greater authority'. (33) Part of the problem, explored in greater detail in the case study, is that it is not possible, despite the exhortations of official circulars, to compartmentalise the respective functions of areas and districts. Inevitably there is overlap between them. The difficulty comes in deciding where acceptable overlap ends and interference begins. In theory, as has been noted, the DEG has the task of implementing policies (essentially an administrative role, as the term has been defined here in order to distinguish it from the area officers' management function) reached by the AEG and the health board. But as a DA said:

the division between area in charge of policy and district in charge of day-to-day management does not really hold. We're getting more and more involved in short-term policy-making. It's inevitable - we're nearer the grass-roots (and) we have access to information the area lacks.

Another DA expressed a similar view. 'Our colleagues at area involve us on the policy side because at the end of the day we are the ones who carry out that policy'. The DA maintained that although something might look sensible on paper, the real question was whether or not it was practicable and to decide this required feedback from the grass-roots. A DFO went as far as to claim that, in his health board, the centre of power lay at district level
because of its close proximity to service operations. He confessed his rejection of the formal division between policy and administration. 'It is difficult to separate management from policy. The area is in charge of matters which affect the area as a whole. The AEG's function is to prevent the two districts adopting different standards and practices'.

The view of the DEG as having a policy planning role is akin to the thinking behind the DMTs in England. But, whereas the role of the latter has been designed with this purpose in mind, the DEG's formal role specifically excludes a policy planning component. But the comments of the two DAs quoted above bear a resemblance to the assumptions underlying the English planning system. As noted in Chapter 3, in England, district plans will provide the basis for all annual planning in the NHS; the value of health planning will depend on the skills of those at district level. Conversely, in Scotland, 'services are principally planned on an Area basis; in the final analysis they are managed on an Area basis' - with the members of the DEG 'being the subordinates of those at Area'.

The comments on the value of districts by the multidisciplinary group in one hospital in a health board (not Alpha or Beta) are worth quoting at this point because they convey many of the key difficulties arising from the area-district relationship, if not from reorganisation as a whole. The multidisciplinary group (comprised of medical, nursing and administrative staff at hospital level) was
unsure of the district's purpose given that 'many matters ... have to be looked at from an area point of view'. The group did not consider DEGs to be in a position to give advice on, for example, the provision of gynaecological beds or the rationalisation of obstetrical services, 'without viewing the problem from an area point of view'. The group said that there was 'a distinct impression ... that too many decisions of the DEG have to be ratified by the AEG and it would seem to us that it would be better either to abolish the districts or to give them more autonomy'. The group expanded on its views, claiming that the DEG had practically no power to take urgent and important decisions but instead was required to go

in suppliant fashion to the AEG or to the (health board). This is in sharp contrast to the pre-disorganisation arrangements when the Secretary of a BoM could demand action from a RHB with the full backing of his BoM whose membership was drawn from all sections of the community, who could view matters from the point of view of the patient's interests and were perfectly capable of making important value judgements. It is this apparent impotence at local level which creates so much dissatisfaction.

Perhaps thrown together because of their shared perception of area hostility, whether explicit or implicit, the DEGs within Alpha and Beta cooperated closely on a number of issues. Apparently, the element of competition noted earlier was not all-pervasive and neither dominated nor determined the relationships which existed. Apart from occasionally strained relations with the respective AEGs, other pressures made for cooperation. For example, the DEGs in each board exchanged minutes so that each group
could follow what the other was doing; often the DEGs discussed common problems; and occasionally they met together with the AEG. According to a DNO in Beta, 'we know what's going on in the other district because the administrators are constantly on the 'phone. I've got a good relationship with the DNO'. A DA pointed out: 'what encourages us (to cooperate) is that there would be nothing worse than to have the two districts operating different standards and implementing different types of policies unless there are good reasons for this'.

Arrangements for meetings between AEGs and DEGs varied between Alpha and Beta. There was no regular pattern, although Beta did begin life with the intention of holding regular meetings. But this was short-lived and meetings tended to occur on a crisis basis (eg if a district was overspending on its budget, or if there were staffing problems), rather than on a regular basis. A DNO in Beta complained that one of the causes of the fractious relationship between his district and the area was that 'we don't meet the area people nearly enough. We tend to meet them when there's a crisis'. Over and above meetings between AEGs and DEGs, individual line managers met each other regularly, usually once a week (eg the DFOs and the Treasurers, the DAs with the Secretaries, and so on). These more formal encounters were supplemented by regular informal contact personally and by telephone.

The questionnaire revealed that in multi-district health boards (ie the six which responded), meetings between the
AEG and DEGs took place between two and four times each year in three of the boards, and on an ad hoc basis as required in the other three. Meetings between chief officers and their district subordinates were more frequent - usually monthly, in two cases five/six times a year. In addition, there was informal ad hoc contact.

When the relationship between districts and areas was under discussion during the field work for this study, district officers in particular were anxious to qualify any criticisms they had with statements like, 'we're just finding our feet now', or 'everything is still settling down'. The assumption behind such remarks was that in time the structure would be able to operate without tensions or conflicts. This seems a valid interpretation and it would be wrong to dismiss it on the grounds that what officers were really trying to do was not to appear critical. However, what this section has tried to show is that other interpretations besides the 'newness' of the structure need to be considered, since these may account more accurately for some of the tensions that were identified. It may be that these are a product of the structure itself rather than its newness. If this is the case, then without further structural change it may not be possible to come to terms with them. Certainly, the tensions encountered represented deviations from the rational model of decision-making, outlined in Chapter 4, which underlay the reorganisation of the NHS.
8.3 Consensus Management

The executive group concept (at area and district levels) is perhaps one of the most significant outcomes of the NHS reorganisation. Executive groups are multidisciplinary, as the previous two sections have shown, and operate as consensus-forming teams. The group concept is considered to be innovatory since it recognises the fact that the provision of health care is essentially a team activity. 'In order to give effect to this team involvement it was... logical to base the reorganised service, to a large extent, upon the concept of multidisciplinary management teams'.(36)

How business is conducted within AEGs and DEGs is of importance since a considerable amount of corporate responsibility is placed upon the officers who comprise the groups, particularly the four chief officers operating at area level. Obviously, the working practices of groups, and the obstacles and/or constraints they encounter in reaching consensus, are complex and varied, and depend to a considerable extent on personalities. No two executive groups, whether at area or district, will be conducted in similar fashion. Nevertheless, some observations can be made based on the field work and on responses to the questionnaire. First, two preliminary points must be made: (1) no member of an executive group can overrule any other member - each member has a veto power and decisions must be reached by consensus; and (2) if a consensus is not forthcoming then the matter in dispute is referred to the appropriate board committee, or to the board itself, for resolu-
tion. Since it might be thought an admission of failure if either an AEG or a DEG has to resort to this latter course, it provides an incentive for groups to settle matters from within.

It is impossible, even if it were desirable, to list the essential ingredients of a successful AEG. Success, however defined, can depend upon innumerable intangible qualities. One possible measure of success is how members of executive groups feel about their roles as consensus team managers.

Neither the English Grey Book nor the SHHD circulars define the term consensus, although great importance is attached to the concept. However, the Grey Book provides more discussion of the management arrangements than the SHHD circulars.

The (multi-disciplinary) teams will be consensus bodies, that is, decisions will need the agreement of each of the team members ... The teams must be small, and will therefore consist only of those whose unanimous agreement is essential to the making and effective implementation of decisions for the totality of health care. (37)

Nevertheless, despite statements like this, there remains 'considerable misunderstanding about the meaning of the concept - consensus decision-making'. (38) Gourlay proposes a model of decision-making processes any one of which may be used by officers in teams to achieve their task: (1) Bulldozing (2) Majority Vote (3) Compromise (4) Consensus (5) Unanimity. While conceding that consensus decision-making is not easy to explain, he is not deterred from offering an explanation.
A person party to a consensus decision will feel that he has had the opportunity of influencing the decision. All the alternatives available will have been thrashed through so that the group have a sound understanding of the problem and possible implications of each decision. They will have reached a decision that optimises the outcome to them. Basically, it is a psychological state in which an opportunity has been provided to influence the decision and the team members are committed to the decision because of this.... Decisions made by consensus are characterised by their innovativeness and the commitment which the team feel to them. (39)

Gourlay's description of consensus decision-making bears a marked resemblance to the description of rational prescriptive models of decision-making reviewed in Chapter 4, which themselves are based on the premise that a consensus exists. It bears less of a resemblance to what can actually happen in executive groups. As an ideal-type model of how the process of consensus should operate, Gourlay's description is valid. But officers in Alpha and Beta looked upon consensus decision-making in less rational (as the term is defined in Chapter 4), and in more political (ie in the sense of power and influence, and organisational routines), terms. Consensus frequently involved compromise which, in turn, meant some gains and some losses for participants. Gourlay defines the compromise decision-making process [(3) above in his schema] as 'typically a negotiating way of arriving at a decision'. (40) The skills of negotiating and bargaining are essential parts of political exchange, and are very much part of any attempt to reach consensus. Therefore, the form of consensus being practised for much of the time in Alpha and Beta had more in common with Gourlay's defini-
tion of 'compromise' than with his definition of 'consensus'.

In response to a question on what they understood by the term 'consensus management', the ten health boards which returned completed questionnaires gave some interesting replies. All but one of the boards described consensus management as management by a group of individuals by mutual agreement. The remaining board stated that 'the team work on a basis of the majority of the team reaching agreement'. This is interesting since consensus management normally refers to unanimous agreement being reached. No wonder that this board was able to conclude that its system of consensus management 'works very well indeed'! One board pointed out that this form of decision-making meant 'administration by a group reaching unanimous decisions on a basis of logical consideration of alternatives or in practical terms an unavoidable shambles'. Another board claimed that consensus management was 'theoretically management by group decision, (but) in practice often acceptance of individual proposed decision by the group. Decisions have always (ie pre-reorganisation) been taken after inter-disciplinary discussion and compromise. Consensus management formalises the situation'. Two other boards also pointed out that present practice and that prior to reorganisation were similar. According to one, 'I would find it difficult to differentiate between consensus management in the post reorganisation era and the multi-disciplinary era in the pre-reorganisation
days'. The other noted that consensus management 'is not really a new feature but merely now a question of formal recognition'.

Boards were asked to cite particular advantages and/or disadvantages with consensus management. On balance, most boards expressed fewer advantages than disadvantages. Several boards pointed out that decision-making was slowed down and 'a lot of paper' was created. Apart from delays (and boards that admitted this qualified their remarks by conceding that the process 'may produce better decisions which the participants all support'), one board reported that access to the group as a whole was sometimes difficult. There was also 'confusion as to what lies within an individual officer's own remit and what should be referred to the Group' (see below). Another board pointed to a more serious problem.

The disadvantage of consensus management is that it enables any member of the Group who feels so inclined to prevent any decision being reached on the matter before it, especially where the matter under discussion has no bearing on that officer's sphere of responsibility and is beyond her understanding.

Another disadvantage cited by one of the boards was the ability of an individual if he/she so wishes to hide behind 'the Team' or even suggest that the influence of other team members has caused the unpopular decision which, had it been his/her individual responsibility through the Board, would not have been made.

Another board maintained that collective decision-making was 'often satisfactory for decisions on multidiscipline matters', but 'is less so when applied to unidiscipline matters involving specialist knowledge. When resources
are scarce, compromise decisions may be reached when they are not the correct and best solution'. On the credit side, consensus management made 'it more difficult (for good or ill) for one person to ignore objections and press on'. Moreover, the system 'has involved certain officers much more in decision-making than previous arrangements did, and this is probably an advantage'. Finally, two boards noted that 'decision-making is no slower than it would have been had it been necessary individually to approach the Authority' (ie as happened under the former structure).

Many of the points and arguments which appeared in responses to the questionnaire also emerged from the field work carried out in Alpha and Beta, and the remainder of this section focuses on the practices of officers in these two boards.

One Secretary described his experience of the AEG of which he was a member in the following terms:

There are cases where we've started off with a disagreement on something. We've always managed to get over it. Somebody has said, 'well, I'm not altogether happy' - fair enough and it's stopped at that. Now, it could go on with one member feeling so strongly about something that he decides to go to the Chairman. It's never happened ... it's bound to happen sooner or later somewhere .... I think before going to a Committee or the Board on a particular matter we try to sort it out privately.

However, some differences of opinion are irreconcilable within the executive group. In particular, a 'low-growth' situation where resources are scarce can place intolerable strains on consensus management. This was the underlying
cause of one AEG's inability to arrive at a consensus on a matter concerning resource-allocation and priorities. Differences arose over whether all available development monies should be allocated to increasing nursing establishments, or whether the monies should be distributed among other services. According to the Treasurer, there would have been no disagreement had it been a normal growth year because the CAMO, who in this instance held out against the monies all being channelled into nursing, would have agreed to an increase in nursing staff in the knowledge that he would still have had access to funds for the development of services under his management. The objection was that nursing was going to receive DF at the expense of all other services, which would have put the CAMO in an exposed position. He would have been open to accusations from medical colleagues of 'selling out' to nurses; moreover, paramedical specialties were all clamouring for staff increases. This small example serves to illustrate that arriving at a consensus was not simply dependent upon harmonious working relationships between officers (although these were important too); external factors could also impinge on the group's discussions and, as the example shows, could be divisive in their impact.

Naturally, consensus decision-making was facilitated by good interpersonal relationships. This was why the CANO in one of the boards thought that the AEG structure was working well. 'I think our secret is because we're so near to each other. If there's any query at all I
usually pop in to whoever I think could help me most. We do a lot informally'. In this board, the formation of good relationships was greatly assisted by the officers having known each other before reorganisation; no member of the AEG had been a stranger to the others when the group was formed. As far as it was possible to ascertain, this was more of a coincidence than a deliberate act of policy on behalf of those making the appointments.

It was the policy in both Alpha and Beta to foster and to encourage informal contact between members of executive groups. The arrangements area and district groups had for morning coffee and afternoon tea provided opportunities for these informal chats to occur. In Alpha, according to the CANO, it was decided at the beginning by the AEG that 'we would have our coffee and our tea together each day ... . We don't waste time over this. Invariably we discuss something which someone is toying with - should I do this, or that? Do I need to tell so-and-so?' The CANO believed that this had 'helped us considerably (to gel as a group)'. A DNO in Beta argued in similar terms. It was his idea 'to have a pot of coffee as the first tool of management every morning'. Discussions were held each morning over coffee and 'sometimes decisions are reached right away'.

Another factor which enabled frequent contact to occur on an informal basis was the close proximity of officers to each other. In both boards, offices were located within fifty yards of each other - only a few steps apart, and a reminder of the importance of the 'office geography'
factor in the politics of decision-making. What one chief officer called 'stairhead' meetings flourished in such a milieu, and much important business and consensus engineering were undertaken on these occasions. There was one exception to this intimate working environment. This concerned a DEG in Beta where the DFO and his department were situated some miles away from the other three members of the executive group, who met on a daily basis without him. To some extent, the DFO was an 'outsider' in other respects since his background was local authority finance rather than health service finance. Consequently, he was at a disadvantage vis-à-vis his colleagues on the DEG and tended to immerse himself in his department in order to come to terms with its practices.

Members of executive groups are not appointed to pursue their own professional interests to the exclusion of all else. In both boards officers tried to interpret and perform their roles in broad terms although, as the answers to some of the questions in the survey showed, there was a very real conflict between their function as officers representing particular health care groups and their function as managers looking at the needs within the area, and planning services accordingly. A CANO expressed it in this way:

I would like to think that I did more than just represent the nursing interest on the AEG. I'm very conscious at times of trying to do so. Occasionally, after a discussion I find myself saying, 'God, that's a non-nursing matter - you really went overboard on it'. I think it is a personality thing more than anything else. Obviously I try
to be the nursing spokesman and fight hard for the nursing part of the budget and so forth. But at the same time I make sure that the case I'm fighting is a reasonable one in terms of being just, needing resources, is sensible in terms of presentation, and that in some measure the timing is right.

On occasion, it was difficult for all officers to possess equal knowledge in regard to every issue. As a CAMO said:

if something is a highly professional matter, the other three (officers) must lean heavily on the one in whose field the matter lies, but that doesn't debar them from inquiring into it and being satisfied, because they have a responsibility too. It is up to the officer with the expertise to convince the others of the rightness of what he is proposing.

Over the question of expertise, the role of the CANO could be significant, particularly in his relationship with the CAMO. There were instances where the CANO was able to act as a counterbalance to the medical viewpoint expressed by the CAMO. Traditionally, the medical voice has been the strongest voice to be heard from among those providing services. Of course it is quite impossible to measure the precise influence a CANO may have since this will fluctuate at any given time, depending on the issue at hand, and on the personalities involved. Nevertheless, both CANOs were agreed that the structural setting (ie the AEG) had a great deal to do with their ability to influence the decisions reached by the groups. Although the ability to influence was in part determined by the knowledge, or perhaps the lack of it, possessed by the lay officers (ie the Secretary and the Treasurer) of the services provided by the board, knowledge alone was insufficient fully to
explain a CANO's influence. According to one of them, the play of influence was more subtle. Having argued that the Secretary knew as much about the medical background of the majority of problems as he did, the CANO proceeded to point out that

at the same time, one occasionally feels that he (ie the Secretary) feels, or administrators generally tend to feel, that they have little right to argue in certain medical areas or certain fields of delivering care. I don't think this is so but some administrators feel this and occasionally one finds oneself being turned to for a second opinion in a discussion on some medical matter where they (feel) that you have an expertise that they don't have ... Sometimes I'm called upon to offer an opinion to counter the CANO but I don't think any counter that I give is based on any special knowledge. I think this is more in the minds of administrators than anything else. They feel somehow that they're not members of the caring profession.

The other CANO was quite clear about the impact he could have on AEG decisions. In his view it was important that nurses should have a say in decisions about allocating money because

the nurse knows more about the medical side than the administrator and Treasurer. A medical person will put a case forward and nine times out of ten the nurse can argue for or against that case, whereas the Treasurer and administrators (can't). A medical person might ask for a certain item of equipment. Normally when medical equipment was ordered (in the past), BoMs very rarely went against what doctors wanted ... The nurse is (now) in a position to say 'but that piece of equipment is only going to be used once a year, you're not going to do that operation every week' because in most cases the nurse knows what the equipment is and what it's for, whereas the lay person wouldn't.

The CANO believed that he acted as a counterforce to medical opinion in situations where the Secretary and Treasurer were at a slight disadvantage.
Members of DEGs all believed that it was possible to reach consensus through compromise despite obvious differences of opinion. It was the primary task at full DEG meetings to formalise much of what had previously been discussed informally. As one DFO remarked, 'we're fortunate here with the four of us being within shouting distance of each other'. It was admitted by one DA that self-interest on the part of group members could predominate early on in discussions because officers were subjected to pressures from their department heads, and demands for more resources came to the DEG for resolution. Normally a balance was struck between the minimum standard acceptable, and a 'super deluxe' service which was the ideal.

It was noted above that CANOs thought they had a special function to perform in AEGs. In one DEG, the DFO thought that his role in the executive group was somewhat different from the roles of his three colleagues. They often asked for the DFO's opinion as a person, as distinct from a finance officer.

Maybe each of them in turn uses me as the non-interested party as far as professionalism is concerned. If there's something contentious that prevents the group from coming to a clear-cut decision, or there's some dubiety, very often they'll look up and ask, 'what do you think?'... In the DEG you've got nursing interests, medical interests and the DA trying to see that everything is played fair and to get a decision made. The DFO isn't there backing any single one. When it comes to things which involve finance, they've (ie other officers) all got their own ideas (which) develop into priorities. Again, as far as I'm concerned, which one gets priority doesn't matter to finance. I'm more impartial than the others. The DA has interests to protect and has to ensure that administrative staff and
ancillary staff and so on are provided for in any new development. My interest is that there's £20,000 for allocation - keep it to that. But beyond that, if one (development) is played against the other (whether another domestic, or another nursing auxiliary is needed) it's of no moment to me.

The DFO maintained that his colleagues 'must defend their own side so that they are not trampled on. I can sit in isolation on this and give pure opinion'.

When compared with a more authoritarian, hierarchical management structure with an emphasis on leadership, consensus management is not a 'soft' option. It can often involve considerable effort, and, inevitably, an element of compromise is present with the result that someone, or perhaps everyone, loses something and does not get his/her/their own way completely. It has already been suggested that no ideal model of consensus decision-making exists (there is even disagreement, as noted above, over what the term means). However, in addition to the problems arising from this mode of decision-making, many officers claimed they had not received sufficient preparation for their new tasks and that this had led to obvious difficulties. To some extent, these probably afflicted all executive groups but one might have expected them to be most clearly apparent in those groups in which there were no compensating factors, such as the existence of strong interpersonal relationships between officers (often formed before reorganisation). This might have accounted for some of the noticeable differences between Alpha and Beta. Whereas Alpha seemed generally to be a more harmonious board with
few apparent incompatibilities, Beta suffered from more friction and tension. An important factor accounting for these differences—might have been that in Beta the chief officers were not all known to each other prior to 1974 (as noted above, this was not the case in Alpha), consequently they had more settling in to do and more adjustments to make. Certainly one member of the AEG did not think that the group was working as well as it should have been, in part because 'most of us brought a fair part of our former roles ... into our new jobs simply because nobody really showed us that there were different models. In actual fact we weren't prepared for our new jobs.' Lack of preparation had led to some distortion of the team management concept. According to one chief officer:

inevitably one found the Secretary operating for a time as the BoM Secretary and Treasurer did, and myself operating as the CNO did, and so on. I don't think we've entirely lost that yet. We still tend to slip back into our former roles and take up positions which .... are not relevant nor particularly useful now... Sometimes I think we tend to be too blinkered in our outlook and I say this embracing myself. We don't take the wider view sometimes because we haven't learned that we should be taking a wider view.

The CANO admitted that

one finds some of one's reactions still being given an unnecessary nursing slant. One sees the CAMO, for example, from time-to-time (and we're all guilty of this) slipping back occasionally into the old autocratic medical role, and trying to steamroller things through, or he will present us with a fait accompli usually on minor things, but it's happening. One feels that these influences are still around whereas I would have hoped that we would have been less fettered by our previous roles, attitudes and so on, and that we would have behaved a little less irrationally in some situations.
It has been noted in a previous section that in Beta the Secretary acted as the chairman of the AEG. Inevitably, this influenced the way in which the group operated. The Secretary chose to chair meetings with a firm hand, preferring to see quick results emerging from group discussions. Such a strategy was not necessarily conducive to the attainment of consensus. An officer cited examples of some of the difficulties.

Looking back, the three of us (CANO, CAMO and Treasurer) are quite happy to sit and talk until 'the cows come home', without necessarily being conscious that we're doing this in order to reach consensus. The Secretary isn't. He's made up his mind and on some things, when he's made up his mind, 'hell or high water' won't budge him. This sort of thing undoubtedly interferes with any move towards consensus because in my book if consensus is important then you really should put some effort into reaching it. I think we should all be compromising. This is the other factor which is inhibiting the AEG from developing ...

It concerns me only inasmuch as it hinders the development of the Group - learning to work together. As you've seen, we get along extremely well on the whole and we work well together. I suppose I'm saying it could be better and that I'm dissatisfied with it to a degree.

Significantly, during the interview, the officer confessed that it was very difficult to have this sort of conversation (ie discussing the operation of the AEG) with his three colleagues.

This is again where I'm disappointed in the AEG - we seldom look at our functioning. Whilst I'm reasonably highly motivated towards doing this, my colleagues aren't and tend to veer away from it .... It's fascinating to look at the mechanics of the AEG from time-to-time because it hasn't gelled yet - it's still very malleable and it's only in this area of stances (ie adhering to former roles); if we could break through that we could develop. Consensus is working after a fashion, but I think it is flavoured by the sorts of things I've been talking about. It's
flavoured by the individual member. I wouldn't say it was true consensus. It's not my idea of consensus because I don't think you can begin to think in terms of consensus where you've got one member saying very firmly, 'well, I'm sorry, I must take my usual negative point of view - we cannot reach consensus'.

The officer was of the opinion that the problems in the ABG were more acute when minor matters were up for discussion.

The major resource-allocation decisions involve a great deal of horse-trading. I think that on the whole that works reasonably well and I think because it is such an important issue we're all prepared to sit down and talk for much longer. So, consensus tends to work well in the major issues. It tends to be undermined by the way it doesn't work in the smaller issues.

The CAMO in Beta was doubtful whether a consensus approach was the right one, or whether it could work in every situation - 'we're all fairly new to this'. He was concerned about the constraints operating on officers which might prevent a consensus approach being adopted, or being practicable, in a particular situation.

Although you can argue at any one time that an undue priority is being given to one thing, so often when making a decision it's a question of 'putting out a fire', or bringing a situation under control ... . Obviously, if there's a 'fire' in a particular hospital in the way of staffing (eg nursing shortages), it's hard to rationalise that against a five-month waiting-list for orthopaedic surgery. I don't know how you do it. I've always argued that a senior person has to have his staffing priorities, but whether you're better to have that done by a group of people rather than by an individual which is what happened to some extent on the hospital side (prior to reorganisation) I don't know. I suppose it could be argued that on RHBs, Secretaries and SAMOs had equal power. Again it's a question of personalities. The RHB I worked in had a powerful SAMO and a subservient Secretary. I think this dominance had
quite a serious effect on nursing because senior nurses felt very subservient to the medical profession.

The CAMOs claimed that clinicians and medical administrators were suspicious of consensus management because whereas in the past they had had the biggest say in management, they felt that they were now getting less say. In the sense that responsibility for decisions is now shared equally (at least in formal structural terms) between four officers there is some truth in the CAMO's claim.

As the questionnaire revealed, a problem with the executive group concept arose in deciding what matters were group responsibilities and what were the preserve of individual officers. One Secretary said:

chie of officers have their own responsibilities and it would be very easy to take to the AEG every issue on which a decision had to be made even though it was an internal departmental matter. One can then shelter behind the AEG.

According to the Secretary, the decision as to whether an item should go to the group for discussion or not was 'an exercise in commonsense. It's up to each officer to decide what issues to raise at the AEG'. A CANO said that what determines whether a nursing matter is put by me to the AEG depends on what I want. If I want money for it (then) it's obviously got to compete so it goes to the AEG. It's usually if I need something from someone else that (a matter) goes to the AEG.

A DNO in Beta came to much the same conclusion: 'I run the nursing service, but where this requires resources or requires help from the other service departments and requires a decision I can't get from a service head, then I take it to the Group'.
DEGs had additional problems to those suffered by AEGs. At district level there is no board of lay members, the equivalent of BoMs, to which officers can refer awkward matters which cannot be resolved within the group. If a DEG was unable to reach agreement on a matter within its delegated authority, the decision had to be referred to the AEG. However, since a referral might be interpreted as indicating a failure of consensus, this acted as an incentive to reach agreement within the group. But as one DNO pointed out, under the BoM system, a 'yes' or 'no' decision was always forthcoming, unlike what could occur with the DEG over some matters. Having to await a decision (or approval) from the area was time-consuming. To this extent, the administrative procedures 'leave a lot to be desired'.

By way of conclusion, it may be said that 'the adoption of a particular consensus style of management has most to do with the personal needs and inter-personal skills of the individuals in a management team'.\(^{(41)}\) Data obtained from the two boards and from the questionnaire did not refute this.

8.4 **Sub-District Management (Sectors)**

It was argued in Chapter 3 that, despite its importance, management below district level had been neglected in the reorganised structure. Many of the problems experienced by sector administrators in Alpha and Beta had their origins in this neglect.

The first mention of management below the district level
is in Circular HSR (72) C3 where 18 lines are devoted to the subject. However the circular declines 'to specify administrative forms applicable in so great a variety of circumstances' since this 'is not appropriate'. It merely stresses the need for clear lines of responsibility running to the DEG for the management of services below district level. Circular HSR (73) C7 does not deal at all with sub-district management since it is to be 'the subject of a later circular'. Not until the autumn of 1975 did a circular specifically concerned with this level of management appear in Scotland. This was Circular 1975 (GEN) 54, which provided health boards with the basic guidance they needed before submitting schemes to the Secretary of State. The guidance given is general since it is accepted that management arrangements required to achieve the day-to-day provision of health care to the public will differ widely according to circumstances.

Health boards can subdivide their districts for management purposes on a geographical or, in certain cases, on a functional basis. Most boards have a mix of geographical and functional subdivisions called sectors. The composition of sectors varies but unless it is a functional division, they normally consist of hospitals, health centres, clinics and related health services. Exceptions to this are large hospitals which constitute a sector in themselves. Circular 1975 (GEN) 54 states that a sector administrator is primarily an executive manager, controlling day-to-day
activities (but see below); he is the focal point for the coordination of all matters relating to services in the community, and in-hospitals, clinics and health centres. The sector administrator also takes part in regular discussions with senior nurses and clinicians, and here his role is a two-fold one, as he is responsible not only for representing the administrative discipline, but also for coordinating multi-disciplinary cooperation. Within his overall responsibility for the smooth running of the sector, the sector administrator coordinates the support services (eg laundries, domestic services, catering), consulting the functional managers about ways in which the supporting services in his sector can be improved. The sector administrator is responsible to the district administrator in his line management relationship, and either the DA or (more usually) one of the general administrators (second-line district officers) is his immediate point of contact at district level.

In Alpha, one of the two districts was divided into four sectors: two covered designated geographical areas, and two covered particular functions/groups of institutions. The other district was divided into two sectors, and both covered geographical areas. In Beta, one of the two districts had only one sector, while the other district was divided into two sectors. The sector administrators in both boards were based on hospitals, which might be large infirmaries or large psychiatric institutions, and operated from these.
There was considerable agreement among sector administrators that sub-district management had been a neglected aspect of the new management structure and that this was making their task more difficult. One administrator said:

sectors have been looked upon very much as an afterthought ... . Whoever devised this reorganisation, it never occurred to them that what they were doing was completely and radically changing the role of administration at hospital level. They seemed to think that we were going to continue as hospital secretaries just with the addition of clinics. That looked very easy and simple on paper, but in practice it hasn't turned out that way. My concern at present is that the sector is the unit where things should be happening; decisions should be taken at sector level. I have a suspicion, and a fear, that decisions are now being taken at district level. We have appointed district officers to investigate long-term planning and policies.... Things are not coming from the sector up; they're coming from the district down.

This structural confusion had led to curious anomalies which administrators were quick to point out. According to one:

I certainly feel that the sector administrator tends to be working in a vacuum. There is no one else at his level to whom he can relate. This is brought home when one thinks of developments. One would have thought that if one is having sectors, districts would look to the sector to produce agreed priorities for the sector. This is not possible. One does it hospital by hospital ... (and) it is the districts who decide priorities even within a sector. To my mind, having created a sector function they either have to recognise it as another tier, or expect it to take the sort of role it is taking.

This administrator felt that he was 'more divorced from the day-to-day work than I was when I was a hospital secretary'.

According to a DA in Alpha, sector administrators were located somewhere between the former hospital secretary
and the group secretary, although there were in fact no real precedents for the role of sector administrator. In particular, the sector role was increasingly becoming a coordinating one rather than a managerial one, the management role previously accorded to the hospital/group secretary having been eroded, if not usurped, by the growth of functional management in the various support services like catering, laundries and domestic services. Sunderland\(^{46}\) argues that

> the drift into functional management has been a consequence of the perceived need, in the past, to improve recruitment to the NHS, which meant competing with private sector salaries. To justify high salaries, pyramidal career structures were devised and to justify the structures functional management theory was cited and invoked.

Recognition of the sector administrator's coordinating responsibility has gone hand-in-hand with a loosening of his involvement in daily departmental management, and authority has given way to coordination.\(^{47}\) A DA in Alpha believed that a sector administrator's coordinating role was on a larger scale than anything previously known in the NHS:

> The hospital secretary used to do some of this but on a smaller scale. Some of the management role of the administrator at sector level is being eroded, (because) all these district functional managers will be responsible to me, (and) the sector administrators will have no direct responsibility. They will have to use techniques of persuasion to get things done. I have structural authority over these people, but the chaps further down the line (ie sector administrators) don't have. They've got to develop other skills to achieve motivation, otherwise all problems will come up to district level. This is destructive and time-wasting.

This appears to confirm Sunderland's\(^{48}\) conclusion that
'the influence of the locally based administrator has declined in the face of both growing functionalism and the multiplying tiers of administration ...'. Sunderland (49) goes further and suggests that 'institutional administration is weak because sector status is weak. It has no back-up support from above and ... it relies for its administrators largely on the young, inexperienced and less able'.

One of the sector administrators interviewed explained that difficulties for him arose from his paradoxical relationship with functional managers.

I'm expected to liaise with district functional managers, expected in certain senses to control them, but they are not responsible to me. I have no jurisdiction over them whatsoever. They are free agents responsible to the DGA (ie District General Administrator). They obviously look to him since he is the link. I'm not, but I'm expected by my administration to link with them, (although) they don't see themselves as linking with me. The whole thing is anomalous.

Although the advent of functional managers had had a marked impact on the role of sector administrators, there was no suggestion that such managers should be abolished. One administrator welcomed their existence in the fields of catering and domestic staff since these categories contained large numbers of staff, and having functional managers to represent their interests and to handle their problems relieved the general administrator of these duties. Another sector administrator was less enthusiastic, and thought that although functional managers had been necessary at the beginning of the new service when
there was much to be done, the danger now was that they might begin to take over the sector administrator's role.

The cult of functional management has transformed the sector administrator's role, with a new emphasis upon coordination. According to one sector administrator,

my role tends to be one where I'm involved mainly in policy work, in meeting with other heads of departments and in agreeing and in formulating policies for services in this sector. That's my prime function as I see it. There's also a coordinating function in relation to certain functional requirements, and that's become more important now.

Another sector administrator proclaimed that his role has changed fairly considerably over the last twelve months. District functional managers have completely altered the whole emphasis in sector. My role is, it's very cliched to say, a coordination role ... Staff directly responsible to me are very few. My role really is to provide districts with information which they require, to ensure that district and area policy is implemented, and to coordinate with the para-medical, nursing and medical staff.

He also maintained that 'the whole coordination role, apart from general administration ... is very hazy round the edges'. Part of the problem was that 'it's not an easily defined job. It's very much more difficult, and I often sit back and say to myself, 'what the hell am I doing? what is my job?' To put it down on paper is very difficult'.

Sector administrators in Alpha and Beta were all located in hospitals but, unless they were in charge of particular functions (eg psychiatric services), they were responsible for community services in addition to hospital ones. It was hard to say whether working in a hospital environment,
for the most part, resulted in the community being somewhat neglected. This was certainly the view of one sector administrator who claimed:

the community doesn't necessarily get a fair crack of the whip. My difficulty in the community is lack of staff. I have one clerkess (which is) my total staff. I have no one to help look after the community. It forms a very small part both in terms of resources and in the total staff of my sector, so it's very difficult for me always to remember the community, and, being hospital trained, I admit that at times I do tend to overlook it. But it's excusable to a certain extent as long as one appreciates that you are overlooking it and try to compensate by being more generous with monies. The SNO (Community) may not agree that we're giving the community its fair share; she thinks that the hospital (service) is trying to gobble it up, but I think it's very much the opposite way round... I try to ensure that what monies we have are distributed fairly and equitably...

The relationship between sector administrators and the professional groups providing services varied from sector to sector. Most boards, including Alpha and Beta, encouraged the formation of multi-disciplinary teams to reflect practice at district and area levels (minus any financial input). In general, in Alpha and Beta, the sector administrators did not experience too much difficulty working with nurses and paramedical staff; many did, however, experience problems with the medical profession (so also did one board which replied to the questionnaire). These did not always stem from doctors' hostility towards sector administrators, but more usually were the result of internal difficulties within the profession. With the passing of the role of Medical Superintendent and the creation in its place of a divisional system; doctors had not found
it easy to choose a medical colleague to act as their spokesman on multi-disciplinary teams. In one sector, the disappearance of the Medical Superintendent had left a void which no one was willing to fill, until the sector administrator was adopted to fill it. 'Not that I wanted to fill it but no one else did so they just automatically turned to me .... For most things I fill the void - not everything. Medical matters go to the DMO'. This was not a satisfactory arrangement and it did lead to by-passing (see above, district/area relationship and professional staff), whereby consultants went direct to district, or even to area, behind the backs of the local administrator.

Many doctors also hankered after the Medical Superintendent figure because they were unhappy with the administration at sector level since 'by and large administrators are younger and are not held in the esteem they once were'. These sorts of problems with clinicians caused difficulties in the setting up of truly multidisciplinary teams. In one sector

the group is bipartite at present - it should be tripartite and we would like a medical component. All the divisions have been asked to send a representative in the hope that one person can become the medical leg of a tripartite.

It could make a difference whether a sector administrator was running a psychiatric hospital or a general medical one. A sector administrator in charge of two psychiatric hospitals thought that

in a psychiatric hospital there always was a
different sort of relationship between consultants and administrators; there always were closer links and an understanding of each other. (Therefore), it's been easier for the sector administrator to be accepted. The structure and methods of working that we're now using have been accepted because in many cases they've been doing that already (ie working in multi-disciplinary teams).

The Chairman of the Area Medical Committee in Alpha argued that there were too many layers in the new structure and too many administrators, many of whom he did not know (nor did he know what they were supposed to be doing). Furthermore, communication channels were far too lengthy with consultation at every level which slowed down the decision-making process. The Chairman maintained that it had been far different under the former arrangements where decisions had been taken in hospitals - the natural units in his view. Even a group of hospitals could form a natural unit, but the present structure was too big. This consultant, and many of his colleagues, missed the old BoM and the Medical Superintendent where contact with administrators and lay board members had been frequent and informal, and action had been speedy.

Apart from entrenched hostility towards the reorganised structure, other factors militated against doctors becoming active in management. For a start, administration and management duties imposed great burdens on doctors. It was not a question of a lack of interest in management (although this may have been so in some quarters); the problem quite simply was lack of time. There was a conflict between administration (ie committee work) and
clinical commitments. But, despite an increase in the administrative work load, there had been no corresponding increase in medical staff to ease the clinical burden which was also increasing. As a result of these alleged pressures, clinical work was not being performed as well as it ought to have been. Furthermore, what administrative work was undertaken was hurried through without the full facts of a case always being considered. The divisional system, according to the Chairman of the AMC, was fine in theory but was unworkable in practice because it clashed with clinical responsibilities. Divisions were disliked, moreover, because they were considered to be a waste of time. Perhaps not altogether surprisingly, the Chairman expressed a preference for the pre-divisional system where each consultant was concerned with his own problems and did not spend much valuable time discussing other people's problems in which he, and others, had little interest. Doctors were trained as individuals to manage their own affairs and were not prepared for wider commitments. Yet, the Chairman was equivocal in his view that divisions had been an unfortunate development. While admitting that a collective say via divisions and the AMC had meant a loss of individual power,\(^{(51)}\) he was not sure if this was necessarily a bad thing. Indeed, in his view, it might be a good thing in that it prevented the emergence of cabals with influence out of all proportion to their standing. Neither was the emergence of powerful individual clinicians, as had been customary prior to reorganisation, possible to the same extent.
Relationships between sector administrators and their superiors at district varied, although in most sectors the point of contact for a sector administrator at district was the DGA. Contact with the DA was less frequent and was normally confined to formal meetings when all the sector administrators within a particular district met together with the DA. In one of the districts in Beta, the sector administrator (it was a one sector district) had a very good relationship with the district officers. Much of this could be attributed to daily contact over lunch at the hospital where the sector administrator was based. After lunch each day the sector administrator would sit down with the DGA and go over everything that had arisen that day. But such a close relationship between sector and district was not typical in the two boards, and the sector administrator admitted that the relationship could occasionally become too close, with the district verging on interfering in sector affairs. Perhaps this was unavoidable no matter what kind of relationship was established, given the existence of only one sector.

Sector administration also suffered from the fact that all administrators at this level agreed that it was a stepping-stone to higher management; this was inevitable in a hierarchical organisation in which a career structure had to be provided. It was the same before reorganisation when a hospital secretary post was a stepping-stone for a deputy group secretary post. As noted in Chapter 3, a Joint Working Party, (52) which examined the role of sector
administrators, concluded that the career structure for administrators in the health service should not 'become too heavily weighted in favour of the higher management function' since this would lessen the appeal, and importance, of management at sector/unit level. Unfortunately, the report does not suggest how this objective might be secured. To some extent, whether or not a sector administrator decides to remain at that level depends on his age, and on his experience. Only one of the sector administrators interviewed was of an age comparable with the ages of officers at district and area levels. The rest were all young although they had had more experience of the NHS than their older colleague, who expressed no desire to move on up the career ladder, being content to remain at the grass-roots (ie sector). In contrast, the other sector administrators expected to move on up the career ladder after spending two to three years or so at sector level.

This review of some of the principal features of sector administration has concentrated on those aspects which have caused particular difficulties, and/or have given rise to most criticism. The approach can be justified on the grounds that, of all the management tiers in the reorganised health service, sector administration has aroused the most passion (most of it unfavourable), especially among members of the caring professions whose first contact with administrators is at sector level. Moreover, there is a conviction among many health care professionals that it is the inherent weakness of the sector level that
is responsible for the delay and confusion which, in their view, is rife throughout the service.

Sector administrators have a particularly demanding, and unenviable, task which they perform in an often unfriendly and unresponsive environment. Much of the criticism surrounding their function seems unavoidable given that they operate at the front-line of a large, complex, labour-intensive activity, and have to relate to a variety of professional groups all making conflicting demands, as well as to patients and members of the public. Because members of district and area management teams lead a fairly sheltered life, out of range of most of the daily flak, it is all too easy to turn to the chap on the spot (in this case the sector administrator) and hold him responsible for lack of funds, and so on. Perhaps the ultimate show of contempt is to bypass the sector administrator altogether.

8.5 Comment

Although health board officers collectively form one element of the policy triad,\(^{53}\) they are a diverse group with differing intraorganisational loyalties, and different functions to perform, depending on the level of the management structure to which they are attached. Moreover, although all officers may be said to be professional, it is possible to make a distinction between those who are members of the caring professions (eg CAMOs, CANOs, DMOs, DNOs, etc), and those, who for convenience may be termed 'lay' officers, whose skills are more generally applicable.

It has been mentioned on several occasions that policy and
administration (or management) are activities which are inextricably bound up with each other. However, it is possible to make a broad distinction between area and district officers, who are chiefly concerned with policy and strategy (particularly those at area), and sector administrators who operate at an institutional level where the policy component of their function is considerably weaker. District officers combine elements of both of these positions (ie the policy and managerial stance, and the administrative, or institutional, stance) and this places them in a somewhat uncertain position. If area officers are making policy, and sector administrators are implementing it, then where, one may ask, does this leave the district officers? In practice the question is not posed because sector administration remains weak and lacks legitimacy, while area officers, to some extent, depend on district officers to provide them with information which will enable them to perform their policy formation function.

It is also true to say that, more than ever before, management in the NHS is dependent upon the establishment of good working relationships between officers at various levels, and on the acquisition of interpersonal skills to facilitate these relationships. Consensus management is demanding, and probably ought to be if it is to operate as intended.

Moreover, the requirement to consult with a myriad of groups, committees and individuals before decisions are
finally taken has placed additional burdens upon officers at all levels. But, paradoxically, the successful performance of this task poses a direct threat to the satisfactory achievement of the other task given officers, namely, to act as efficient managers with a stress on decisiveness and rationality. Clearly, these two aims, participative management (through elaborate consultative procedures) and efficient management, are not necessarily compatible with each other. Not surprisingly, they have led to distortions in the logic of the structure. Inevitably, consultation is a lengthy process which can slow down decision-making and render useless attempts to act quickly and efficiently. On the other hand, if steps are taken to short-circuit this tortuous process, this can be to the detriment of the issues being decided. The growth of disputes within the NHS has many causes, one of which is the complexity of the consultative process since reorganisation. Another is the existence of a multi-tiered structure which has served to distance staff from management. The consensus style of management, and the need to consult widely, make it difficult for service providers actually to see who is ultimately responsible for a particular decision. The new structure lacks a focal point, like a chief executive, having instead layer upon layer of management without a centre of power. Although officers operate within hierarchies (with the exception of the medical profession), the hierarchies are incomplete; consequently, the management structure resembles a flattened pyramid, or a ladder without a top step. In practice,
what exists is a never-ending loop of consultation and consensus management. What one has, therefore, is a mix of two conflicting management styles - the mechanistic, signified by a line management structure, and the organic, signified by the emphasis on consultation and consensus - which coexist uneasily in the same organisational structure. The mechanistic, or closed-system, perspective views organisations as instruments designed for the pursuit of clearly specified goals. Organisational rules, procedures and regulations are derived from the goals in order that the latter may be pursued in a rational manner. The organic, or open-system, perspective views organisations as not only concerned with goals but as also responding to external and internal pressures. It stresses the interdependence of the parts of organisations, and their structure is designed accordingly, with an emphasis on flexibility and consensus (where this can be achieved) rather than on rigid forms and authority. Because elements of both theoretical perspectives are present in the management structure of health boards, a consequence of compromises forged during the process of reorganisation combined with an attachment to a rational model of decision-making, many of the tensions and ambiguities that have been touched upon in this chapter stem, however indirectly, from fundamental structural incongruitities in the management arrangements. Further evidence of these at work is given in later chapters.
Chapter 9

THE POLICY TRIAD:

DRAMATIS PERSONAE (3) ADVISORY STRUCTURE

(PROFESSIONAL AND CONSUMER)

To complete the description of the policy triad, it remains to examine the professional and consumer advisory groups within health boards. The advisory structure is a significant feature of the reorganised NHS since it is through this channel that service providers and consumers can communicate their views to officers and to board members, as well as comment upon proposals for the development of services. The service professions listed in the NHS (Scotland) Act 1972 who are entitled to form committees are: medical practitioners, dental practitioners, nurses, pharmacists and opticians. In addition to these groups, the paramedical professions have also formed committees; the composition of these varies from board to board because a number of occupational groups, like laboratory technicians, would prefer to form separate committees of their own rather than join a committee which tries to represent the interests of all paramedical professions.

This chapter concentrates on the three most important advisory committees, in terms of the decision process observed: medical, nursing, and paramedical. In Alpha, there are no district consultative committees, only area ones; in Beta, there are consultative committees at district and at area. The structure in Alpha is unique to
that board. In all other multi-district boards there are corresponding foci of professional advice at district level.

In fairness, it ought to be said that when the field work was being carried out, these committees were in their infancy. This might explain why their impact on the decision process observed was minimal. However, it is still necessary to consider the advisory structure because it is an element in the decision process and it is capable of exerting an indirect influence on this process even if a direct influence is still lacking. Officers in Alpha and Beta were very much aware of the existence of advisory committees and were conscious of their obligations to consult the committees about policy developments.

9.1 Medical Advisory Structure

Few would disagree with the claim that the medical advisory structure (MAS) in most health boards is perhaps the best organised of all the advisory committees (this is not to imply that there are no problems with the MAS; quite clearly there are, as an unpublished review of the structure by the SHHD in 1975/76 shows). However, the MAS was the subject of two official reports, the second of which emphasises the importance of an advisory structure for the medical profession. It points out that reorganisation has given rise to a new management structure in which executive authority and professional advisory machinery must interlock in partnership. The new arrangement gives the profession an opportunity to influence and guide the administration of the service and, in our view,
lays upon it a positive duty to do so. (4)
The report asserts that 'the profession will be expected
.... to initiate proposals and to influence policy at all
levels'. (5) Moreover, 'the MAS will be required ... to
provide a channel of access to management, to express a
corporate medical viewpoint, and to provide a general
background of accepted medical priorities'. (6) The report
states that it is of great importance 'that the view that
is put forward to management should be co-ordinated, res¬
ponsible and realistic', and advises that 'health boards
should look to their Area Medical Committees (AMCs) as
the source of collective advice and considered opinion
from the medical staff in their areas'. (7)
The AMC is the only part of the MAS below national level
which is statutory. Such a committee is recognised by
the Secretary of State provided he is satisfied that it is
representative of the medical practitioners in the area it
serves (this proviso also applies to other professional
advisory committees). In practice, this has been inter¬
preted as requiring equal representation by GPs and hos¬
pital doctors. The problem is that, in order to satisfy
the requirement for equal representation and for the
diverse needs of hospital practice, committees may have
become too large to be effective. The size factor was
certainly evident in Beta where the AMC had a membership
of 36; this compared with a membership of 20 in Alpha.
In both boards, CMSs and CAMOs could attend meetings by
invitation but they were not members.
One of the chief problems which faced members of the AMCs in Alpha and Beta (and, one would imagine, elsewhere too) was the shortage of time to perform clinical duties and cope with administrative commitments. As it was, the AMC in Alpha had to meet in the evening because this was the only time which suited GP members. The Chairman of the AMC commented that of all the members, GPs were the most keen on administrative work. He thought this might be because they now felt part of the NHS. More than this, as a CAMO argued, GPs are now in a position to challenge hospital doctors, forcing them to justify their demands for more resources. Consultants were less interested in the MAS and did not share the GPs' enthusiasm for it. One reason for this may be because consultants see their authority as individual clinicians being eroded with the advent of the MAS with its equal representation of GPs and hospital doctors.

In Alpha, the AMC had problems with the two-district structure since (1) there was no MAS at district level, and (2) the AMC was seen as biased towards one of the districts. Although members were drawn from the whole area, the AMC was not only based on one of the districts (inevitably), but its Chairman, plus ten of its members, had their main base in hospitals in the same district. The situation might have been tolerable had it not been for the fact that this particular district was considered to be the favoured one in terms of resources and facilities (eg it had a spanking new general hospital which was the envy of the
medical profession in the adjoining district). These divisions between the two parts of the area were historical, and did not owe their origins to the 1974 reorganisation, although the division of the area into two districts may be said to have reinforced and perpetuated the split.

In general, relationships between the AMCs and AEGs in Alpha and Beta were harmonious. Certainly in Beta, the Chairman of the AMC was a frequent attender of AEG meetings. AMCs (as well as other advisory committees) have direct access to health boards. The CAMO in Alpha said that there had often been disagreements between himself and the AMC but that it was up to the board to come to a decision. He pointed out, however, that it was 'not in the board's interest to force something through which goes against the AMC because they won't cooperate in carrying it out'.

Of all the advisory committees, the AMC was the best organised (this was so in Alpha and Beta, and most probably elsewhere too) and the most active. This is not to imply that there were no difficulties, only that other committees had more of them. In the AMC's favour was the fact that officers looked upon it as the most important committee and the one to watch out for. Moreover, in view of the advance preparation, it was hardly surprising that the MAS made such an impression.

9.2 Nursing Advisory Structure

The Area Nursing and Midwifery Committees in Alpha and Beta were not viewed in the same way as the AMCs, and were
in general considered to be rather disappointing. In Alpha, the Nursing and Midwifery Committee was set up shortly after April 1974. It meets officially every two months, but meetings are held between certain members if a matter comes to the committee from the board which has to be discussed before the next official meeting. Subcommittees have been formed to investigate particular problems, or to examine official reports; for instance, a sub-committee was set up to look at the transfer of gynaecological services from one hospital to another. The Chairman of the committee thought that having meetings for the whole committee every two months was quite adequate when the sub-committees met in between. A problem at the start had been obtaining clerical assistance but this had been resolved.

The committee had a membership of fifteen which was representative of the various professional associations, trade unions and nursing specialties. Membership was stable and the turnout for meetings was high. The Chairman admitted that there was some difficulty in those cases where nurses on the committee (charge nurses and enrolled nurses) were junior to the Chairman (who was a PNO) in the work situation. She said: 'they don't yet see the committee as a place where everyone has an equal say'; moreover, they were reluctant to contribute to discussions.

The committee discussed a range of problems, from the adequacy of staff numbers in the hospital service and in community services, and how to make a success of integra-
tion, to the effects in the area of the Briggs report on nursing. The Chairman claimed that the committee had been given a tremendous amount of work by the board; in addition to commenting on proposals put to it by the board, or the AEG, the committee had submitted suggestions of its own to the board in the form of reports.

As noted above, there was no district advisory structure in Alpha, but the Chairman of the Nursing and Midwifery Committee kept the two DNOs informed of all that went on in committee, principally through allowing them to see agendas, minutes and any reports that were prepared. The Chairman, not surprisingly perhaps, was not in favour of having a district structure complementary to the area structure on the grounds that 'you must see the area as a whole. I don't wish to see the fragmentation of responsibilities. (There is a) danger of over-consultation and too many committees'.

The CANOs in Alpha and Beta were both doubtful of the need for a nursing advisory structure. One argued that with Salmon there wasn't the same need for a nursing advisory committee because the committee is made up of eight functional heads and another eight who are representatives of the various organisations. They are all my staff and because of our management structure in nursing, sometimes I wonder if this (committee) is not a duplicate.

The CANO firmly believed that if communications were good within the line structure between superiors and subordinates then a nursing advisory committee was superfluous. Only 'if there is a block and, say, the SNO doesn't communicate with those below her then at least the advisory
committee provides a means of counteacting this. The advisory committee is valuable on these occasions only.'

The CANO added that he could not 'see the committee being as strong as the medical committee. I think the medical committee needs to be (strong) because they don't have a line management structure'.

The CANO in Beta was also unenthusiastic about the nursing advisory structure. He thought that

in some ways the advisory committee has been a disappointment. I think because the members are in line management they get into difficulties inasmuch as they are giving advice wearing two hats. The majority of members are my advisers, whom I would normally contact if I wanted advice. So, in a sense, they, as individuals, are being asked for advice through two channels - under their officer hat, and under their advisory committee hat. The Area Nursing and Midwifery Committee really haven't emerged as any sort of force; they haven't really fully appreciated what their function is. As a committee, they are not well organised. We can wait anything up to two months for advice from them.

The CANO admitted that this was due in part to the timing of the committee's meetings but thought also that there was an 'administrative naivety' pervading the proceedings. The CANO had no complaints about the advice received, 'but then I usually have it already through other channels'. Like his colleague in Alpha, the CANO claimed that the AMC performed well, 'as one would expect'.

9.3 Paramedical Advisory Structure

The paramedical advisory committees in Alpha and Beta were a 'hotch-potch' of professional, or, to use Freidson's term, 'paraprofessional' groups. The Area Paramedical Committee (APC) in Alpha comprised representatives from
radiography, chiropody, physiotherapy, occupational therapy, dietetics, speech therapy, and orthopaedics. It is putting it mildly to say that achieving consensus, or any form of agreement, among so many different groups, each with its own set of interests and aims, is not easy. However, the APC was assisted in its work by one strong unifying factor—a desire to be independent of the medical profession. Having an advisory committee allowed paramedical groups to participate in decision-making in their own right, without having to depend on the medical profession to represent their interests. Before reorganisation, the medical profession took decisions on behalf of paramedical occupations after a minimum of consultation, and paramedicals had no real say in decisions affecting them. But because advisory committees had direct access to the AEG and the board, the medical profession was excluded and bypassed by the paramedicals. The advisory structure has, therefore, probably been of most value to paramedical groups since they have been able to achieve recognition of their independent professional status.

In Alpha, the APC, according to its Chairman and Secretary, was operating quite smoothly, and many of the frictions encountered initially had more or less been overcome. At the start, there had been a reluctance to attend meetings, because the committee was regarded by many as a waste of time and rather useless. But attendance had become more regular and the committee was seen to be a useful mechanism for making the wishes of the various paramedical groups
known. Membership of the committee had also posed some difficulties. Paramedics, as noted already, form a diverse group of occupations, and some people were of the opinion that the groups had little in common with each other, and that to have them all represented on one committee was asking for trouble because they would never manage to reach agreement on any issue. However, it was claimed that the committee had not operated in this way; while there had been some friction initially between physiotherapists and radiographers, this had been ironed out. Of more significance, perhaps, was a feeling at the beginning that problems could not be shared - how could everyone understand each other's problems? No one, apart from the person with the problem, was in full possession of the facts. Moreover, why would anyone want to become involved in someone else's problems? Inevitably, therefore, the original perspective of the APC and its members was a rather narrow, self-interested one: no one knew what was happening outwith one's own professional boundaries, and, furthermore, had no particular desire to know. But once the committee was fully operational, this perspective began to shift, and there was a greater awareness among members of each other's problems. It began to be accepted that suggestions from 'outsiders' were useful in solving a problem, since fresh insights were often introduced. Moreover, a greater understanding of the difficulties of others meant that a constant clamour for resources for one's own specialty, to the exclusion of everyone else's, gradually gave way to a more responsible, and realistic, attitude. Resources were
limited, so priorities had to be set.

The Secretary of the APC thought the committee was working well and that part of the credit for this must go to his ability to act as a 'neutral' Secretary. Because he was a medical photographer, he was outside the main professions supplementary to medicine. His view was that a different, less congenial situation could have developed if a physiotherapist or a radiographer had been, or were to become, Secretary.

In Beta, the APC had gone through similar difficulties in getting established and in gaining acceptance. However, the CANO did not think that the committee was a great success. In his opinion 'the paramedicals are in a worse position than nurses; they have less in common. One hears very little about them, and one assumes that things aren't going well'.

In general, advisory committees operated independently of each other, although there were occasional exceptions to this. According to replies to the questionnaire, some health boards try to encourage advisory committees to meet together to discuss joint topics, and in one board the AEG drew together the chairmen of the committees at regular intervals for discussion. In Alpha, the advisory committees all exchanged minutes. This was unusual and was not a feature in other boards, apart from one which replied to the questionnaire, although in this case the distribution of minutes was undertaken by the nursing committee only.

In Alpha, the idea for exchanging minutes came from the AMC.
To begin with, the other committees were suspicious, especially the APC, some of whose members thought that the real motive behind the idea was to enable the medical profession to reassert its authority and autonomy over other health care groups that were no longer under its control. However, the system, once in operation, appeared to be a helpful way of keeping the advisory committees informed of each other's activities.

As responses to the questionnaire revealed, views concerning the value of advisory committees were mixed. A few boards believed that professional advice was necessary and welcomed it. One board said it was useful to be able to say that advice had been received from a committee representing a profession. Another board claimed that advisory committees improved communications. However, several boards were not convinced of the value of an advisory structure. Occasionally their criticisms applied to the whole advisory structure, or, in some cases, to specific committees. One board replied: 'some of the committees are doing quite a good job, others less good. It seems to me that some of the committees are there for 'political' reasons, and for the status of the profession rather than for what they can do'. Another board replied that although 'the psychological effect within the professions by the recognition of advisory committees might be relevant ... in practice there would seem much doubt of their value in the minds of many members of the professions concerned'.
Two boards pointed out that advisory committees could slow down decision-making, because they added to the vast amount of consultation that had to be undertaken. Another board pointed out that while advice was welcomed by the board, 'it is not always easy to differentiate between advice and management roles, especially between the executive group and advisory committees, and between advisory committees and unit management teams'. Two boards agreed with the CANO in Alpha (see above), who considered the nursing advisory structure to be of little value. One of them claimed that the Area Nursing and Midwifery Committee was 'totally ineffectual'; the other was of the opinion that the committee served 'no useful function' because of the hierarchical structure of nursing. Finally, the same two boards were critical of their respective paramedical committees. In one of the boards, the committee had little real impact 'due to the small numbers of staff involved'; in the other, the paramedical committee, despite repeated advice, insisted 'on discussing topics outwith their terms of reference, eg conditions of service, probably because they have nothing else usefully to discuss, and they tend to be a militant bunch anyway'.

9.4 Local Health Councils (LHCs)

LHCs are independent bodies, standing outside the formal management structure. They have been set up by health boards under schemes approved by the Secretary of State. LHCs are strictly advisory bodies, and are empowered to consider questions relating to the health services in their
area or district, to submit reports to health boards on
the operation of services, to obtain information from
boards, and to visit health service establishments. Coun-
cils are also required to submit annual reports to their
health boards.

LHCs were the final components of the reorganised structure
to be established. During Year 1 of the research project
they were in the process of being appointed, therefore, in
Year 2, their impact on decision-making was inevitably
rather limited (see further below), although towards the
end of the research period, the LHCs in Alpha were begin-
ing to make an impact on the deliberations of the board.
There was less activity in Beta during this time; officers
and board members were engaged in discussions to decide on
an appropriate procedure for consulting LHCs on planning
proposals, developments, and so on.

As in the case of professional advisory committees, it is
necessary to say something about the operation of LHCs in
Alpha and Beta because officers and board members were
conscious of their existence, and of the need to involve
them in decisions and plans. This awareness was an ele-
ment in the calculations officers had to make as to what
might be acceptable, or unacceptable, to certain interests.

LHCs can be observed from two diametrically opposed per-
spectives. On the one hand, there is the view that these
bodies represent a novel, but significant, experiment in
democratic participation, 'a quiet social revolution' in
the words of one observer. (12) Owen, (13) among others,
subscribes to this view. In his opinion, the decision to establish CHCs (ie the English equivalent of LHCs) will probably be looked back on by social historians as the most significant aspect of the whole of the NHS Reorganisation Act of 1973. For the first time there exists a strong consumer voice both to criticise and champion the NHS.

On the other hand, there is the view that with the strong emphasis on management in the reorganised NHS the ability of consumers to make a significant impact on policies and priorities is almost nil. 'Policy control is made a matter for managers and the centre rather than for those directly affected by the policies'.(14) As Draper et al point out, LHCs have no executive powers. The authors argue that 'the Consultative Document(15) made it clear that the government saw these bodies essentially as institutions that would 'react to management' rather than be a part of it',(16) and conclude: 'such-bureaucratic systems (ie the reorganised NHS which 'reflects a mechanistic and technocratic orientation') are the antithesis of the democratic ideal'.(17) On the strength of these views, LHCs could be described as purely 'cosmetic committees', designed to make outsiders think the patient/consumer has a say.

A third view of LHCs, which was expressed frequently in Alpha and Beta, particularly by some board members, perceived these bodies to be a nuisance, an irritant and really rather irrelevant. Of all three conceptions of LHCs, this was the most prevalent. Very few board members perceived LHCs as exciting new bodies with great potential, and no one adhered to the view that there was too little
democracy in the NHS and that LHCs should be granted executive powers and have business delegated to them.

In Alpha, a draft scheme for the establishment of LHCs was put before the board in August 1974 with comments on the scheme that had been received from interested parties. The draft scheme was the outcome of previous discussions by the board on its intention to establish three LHCs, their boundaries coinciding with the boundaries of the local government districts. In accordance with Section 14 of the NHS (Scotland) Act 1972, local authorities (region and districts) were invited to appoint members to the places allocated to them (about 1/3 of the total membership of each Council), and the health board appointed the remaining members after consulting voluntary bodies, trade unions and other interests, usually individuals with special knowledge of the health service. Two of the LHCs had 23 members each, and the other had 19 members. Table 9.1 shows how the three LHCs were constituted.

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<thead>
<tr>
<th>Local Authority Appointments</th>
<th>Voluntary Bodies</th>
<th>Trade Unions</th>
<th>Other</th>
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<tbody>
<tr>
<td>LHC 1</td>
<td>8</td>
<td>9</td>
<td>3</td>
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<tr>
<td>LHC 2</td>
<td>8</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>LHC 3</td>
<td>7</td>
<td>8</td>
<td>2</td>
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Members are appointed for a four-year term. One half of the first round of members were appointed for a term of three years (including all district local authority members); the other half were appointed for a term of five
years. LHCs appoint one of their number as Chairman.

In Beta, the procedure for setting up LHCs was similar, although different arrangements were favoured. During initial discussions among board members on the number of LHCs that would be desirable, there was support, particularly from the Chairman, for having only one LHC as opposed to having either two (one for each health board district), or three (to coincide with the local government districts). The Chairman favoured one LHC for the entire area because he believed that one Council might result in a more balanced reaction than the parochialism which might prevail if a number of Councils were considering a proposal which benefitted, in the main, only one part of the area. Moreover, communications between the board and the Council would be simplified. The size of the Council, it was thought, would be close to the maximum number recommended (28 members), made up as follows: local authorities (region and districts) - 10; voluntary organisations - 12; trade unions - 3; and others - 3. Not all board members supported the scheme for only one LHC; many expressed the view that one Council could not be sufficiently 'local', and would not adequately reflect the views of people in all parts of the area.

Neither was the scheme for one LHC well received by the interested parties who had to be consulted. They had a preference for two or three LHCs to ensure adequate local representation. A revised scheme was prepared proposing the establishment of two LHCs, one for each health board
district. Each Council had fifteen members, constituted as shown in Table 9.2.

**TABLE 9.2 Breakdown of LHC Membership (Beta)**

<table>
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<tr>
<th>Local Authority Appointments</th>
<th>Voluntary Bodies</th>
<th>Trade Unions</th>
<th>Other</th>
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<tbody>
<tr>
<td>LHC 1)</td>
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<td>6</td>
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<td>LHC 2)</td>
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It is worth noting that the membership of LHCs is very similar to the membership of health boards. With few exceptions, the members of both sets of authorities are drawn from the same social strata.

Because their terms of reference are rather vague, LHCs have considerable freedom to operate in a variety of ways. This freedom, although valuable, also posed problems for LHCs. For most, the first year was a time of consolidation while they familiarised themselves with the services within their areas, and decided on strategy. A perusal of the first annual reports of LHCs (not just those produced by Councils in Alpha and Beta) revealed that Councils were taking their time. The following statement from one report is typical: 'we feel that in our first year we have been, and indeed still are, very much in a learning situation'.

The report elaborated on this, saying that from the very outset many of us were aware of our acute lack of informed knowledge of the NHS and of the need to proceed slowly with making recommendations until we had familiarised ourselves...
with the administration and day to day running of the Health Service. (19)

One of Beta's two LHCs reported that they 'had to look around carefully listening to and looking at the situation as comparative newcomers to the business'.

All the annual reports examined commented on the problem of members' ignorance of the NHS and the attempts being made to try and overcome this through training and educational programmes. Most of these had taken the form of reading the literature on the NHS, visiting institutions, listening to experts invited to speak to LHCs, and attending conferences aimed at explaining to members the operation of the NHS. Inevitably, the value of such exercises varied from one LHC to another. Although some LHC members might have had previous experience of the NHS (eg former BoM members), others, like many health board members, did not have this background. But whereas health board members could, as a last resort, seek assistance from officers this was not a serious option for bewildered LHC members. Therefore, as one LHC Chairman noted, 'the tasks of learning and evaluation are formidable but absolutely necessary if we are to discharge our responsibilities properly'.

It has been suggested (20) that there are a number of strategies available to LHCs to enable them to perform their tasks: (1) Consensus, rational approach involving 'soft' tactics; LHCs operate closely with management in an attempt to accommodate each other's views in an amicable manner. (2) Campaign strategy - persuading people by
lobbying them through the media; LHCs try generally to stir things up. (3) Conflict approach - LHCs may choose to enter into conflict with health boards, particularly if the latter consistently refuse to respond to LHCs' advice. Of these strategies, LHCs in Alpha and Beta tended to pursue either (1) or (2). The strategy chosen was dependent upon a variety of circumstances, among them the objectives of a LHC. If these changed, then the strategy pursued to fulfil them also changed. An example will suffice to illustrate the process. One of Alpha's three LHCs adopted strategy (1) initially when the board wanted to streamline its maternity services in the area. Board policy was in line with the recommendations contained in the SHHD's priorities memorandum: with the declining birth rate 'some reduction in expenditure in (maternity hospital provision) must be looked for ... through the closure of under-used units and the concentration of services'.(21) Because Alpha was about to open an extension to a maternity hospital in another part of the area, there was less need to maintain a maternity service in the northern part of the area (ie represented by the LHC). The fact that the maternity hospital threatened with closure had an occupancy ratio of only 52% lent added weight to the board's case. Following upon the LHC's request for proposals regarding the future of the maternity hospital, the board submitted various alternatives. The LHC, however, rejected these (although it was broadly in agreement with the board that maternity services in that part of the
area required attention), and recommended the need for a reappraisal of all health care facilities in the area it represented. The LHC set up a sub-committee to devise proposals to submit to the board, and, in the course of its deliberations, entered into a creative dialogue with the board, even going so far as to suggest a possible option for the maternity hospital which the board itself had not considered. However, it soon became apparent to the LHC that there was strong public support for the retention of a full maternity service in the area it represented so as to avoid the considerable inconvenience that would be incurred by a concentration of maternity services at the new extension. Although it was clear that the LHC was not representing the local community's views, the sub-committee considered that the primary aim was the provision of the best possible service to the community within the limited financial resources available, allied to the maximum use of present facilities, which meant that the retention of a full maternity service on a small scale was not a viable proposition. It suggested an alternative use for the maternity hospital. The proposals were adopted by the LHC and were submitted to a joint meeting with representatives of the health board. The board indicated interest in the proposals although they would require further study. At about this time, the strategy of the LHC began to change. Having been at pains to cooperate constructively with the board and its officers, having agreed with their general analysis of the need to rationalise maternity services, and having submitted pro-
posals which had impressed the board, the LHC began to realise just how much local public opposition there was to its stance on the maternity issue. In a belated attempt to realign itself with local opinion, which it possibly perceived to be its true purpose despite earlier beliefs, the LHC shifted from strategy (1) to strategy (2), and took up a campaigning stance against the board's plan to concentrate the area's maternity services on the new unit.

The incident highlights a further dilemma concerning LHCs and their relationship with health boards. To what extent can Councils cooperate with management in developing satisfactory health services within an area without, at the same time, alienating themselves from the local communities they are supposed to represent? As one observer has written, the Councils 'are treading a difficult path between populism on the one hand, and over-identification with the authorities on the other. Either could render them ineffectual and friendless ... .' (22) The LHC involved in the maternity case described above touched on this point in the conclusion to its first annual report:

The Council has been at pains to adopt, in its relationship with the Health Board, a realistic attitude to problems and deficiencies in the service, while reflecting the best interests of the people in the (area) within the context of the limited financial resources available to the Health Service.

The Council welcomed comments and views from the public to 'enable the Council truly to reflect the views of the community in its relations with the Health Board'. These aims may appear reasonable and feasible on paper, but in
practice any superficial appearance of reconcilability quickly vanishes.

The problem of to what extent, if any, the public is aware of, or interested in, LHCs is a sensitive one for most LHCs. They realise that large sections of the public are totally unaware of their existence and that of those who have heard of them, many associate LHCs with the management structure, an association that is given some validity by virtue of the fact that many LHCs, albeit reluctantly and, hopefully, temporarily, operate from health service establishments. Not only are LHCs identified with management if they are tucked away in some hospital, but they remain inaccessible to the public. One annual report suggested that LHCs ought to be situated in main streets with shop windows to attract people and to explain to them what LHCs are for and what they are doing on the public's behalf.

LHCs, whose members (like health board members) do not represent the particular groups from which they are drawn, but the community as a whole, have seen it as their function to interpret to health boards the feelings of the community. This is stressed in several annual reports. But the problem, as has been noted, is how to represent a public that is often ignorant of the existence of LHCs. Since there are no elections for LHC members, the only way to achieve this objective is through publicity. All LHCs have participated in poster campaigns, and all feed the local press with information in the form of agendas,
minutes and reports. LHCs operate different procedures in regard to the attendance at meetings of the press and public. For example, one Council was equivocal on this. While local representatives of the national and local press were invited to attend Council meetings, a few items required to be dealt with 'in committee'. Lack of accommodation precluded the Council inviting the general public to attend, though anyone who came would not be turned away. Other LHCs, however, did not admit the press to meetings, on the grounds that it was sufficient for the press to receive statements on any items which the Council thought required publicity. Press coverage, when it occurs, has tended to be confined to controversial matters like the siting of a health centre, or the closure of a hospital. It is hard to see, therefore, how the press, or publicity of any sort, will assist LHCs to achieve the goal expressed by one Chairman. He wrote

Monitoring the Health Service ... is not the only function of a newly formed Council... It is to be hoped that the creation of Health Councils will lead to a widespread and informed discussion of the nature of health and to a greater determination to achieve it. (23)

LHCs in Alpha and Beta (as elsewhere) concerned themselves with a variety of subjects, including the problem of transport to hospitals of patients and their friends, remedies for long waiting lists, fluoridation of water supply, alcoholism, and visiting hours. Some matters were submitted to Councils by their respective boards (ie Alpha and Beta) for comment, others were brought to the attention of Councils by members of the public, and a few issues were
raised by LHC members. Councils have devised their own working procedures. In Beta, one of the LHCs had formed three committees: one to look after primary and long term care, another to keep under review maternity and child welfare services, and a third general purposes committee. In Alpha, one of the Councils had reformed into five working parties, each identifying with a particular client group: care of the elderly, mental health, maternity and allied services, child health, and health service matters in general. Another LHC in Alpha was considering the formation of special interest groups which would facilitate more detailed study of specific aspects of health care services.

From data derived from Alpha and Beta, there appeared to be two problems which arose from the consultation of LHCs by health boards. These might turn out to be temporary, but at the time of the field work they underlay the tensions which were present in the relationships between Councils and boards. The first problem arose from LHCs' disadvantage vis-à-vis permanent professional managers who, in one or two instances, made no secret of the fact that LHCs were there to be used. According to this view, it was up to the officers to win LHCs on to their side in order to obtain the Councils' support for particular schemes which the officers were anxious to implement. Some officers looked upon LHCs as having a public relations function which could be useful to them if they wanted, for example, to open a health centre in the face of opposition from local GPs. The officers could turn to the appropriate LHC
in such an event and, through publicity, bring pressure to bear on the recalcitrant doctors. LHCs were aware of the political nature of their role but, regardless of whether the objectives of both parties were similar, LHCs were, to a great extent, at the mercy of officers since the balance of power, or influence, rested largely with them, particularly when LHCs had formed rather fragile links with their public. Lack of expertise was also part of the problem, and in reviewing proposals for a major building programme, one LHC felt inadequate and not up to the task of appraising it. It was, the Council claimed, a document which really needed professional consideration. The Council, therefore, had little option but to agree to what the board had proposed. In the circumstances it would have been extremely difficult to have done otherwise.

In Alpha and Beta, as mentioned in Chapter 7, LHCs were not held in high esteem by most board members. To many members, the Councils were either an irrelevance or a threat; only to a few did they represent a new departure which ought to be welcomed. Officers' opinions on the subject of LHCs were more neutral. They accepted that the Councils had to be consulted, and that it was their function to achieve this as expeditiously as possible. It was the question of how consultation should be conducted that led to the second of the two problems identified above: at what stage in the planning process should LHCs be consulted? The issue has not been satisfactorily resolved in every board. An exception was one of the LHCs in Alpha.
The Council had always been anxious that there should be consultation at the earliest possible stage in any proposals substantially to alter health care provision by way of a change of location, extension, contraction, or discontinuation. This need had been fulfilled by differentiating between the preliminary fact-finding stage, and consultation proper.

In Beta, the working out of an appropriate procedure involved lengthy discussion. Although the view of the SHHD was that LHCs should be involved at the earliest possible planning stage, board members in Beta were not happy with this arrangement since they objected to LHCs being consulted before they had been. The precise reasons for their objections were not clear cut but probably had much to do with the fact that board members were, in many cases, just naturally suspicious of LHCs. They felt that the Councils would be usurping their role, and devaluing it in some way, if they were consulted about schemes before board members had even heard of them. Moreover, there was perhaps concern among board members that they could not reject advice coming from LHCs since the latter represented the community, a role which many board members maintained was theirs. In short, for board members to be seen to oppose the advice of LHCs might be interpreted by the public as board members siding with management rather than with the community interest. The AEG's view in all this was that plans should go to the LHC before being submitted to the board. Advice from LHCs was essential before matters went to the board since decisions were made by
board members on the basis of advice received from numerous bodies, including LHCs.

The dispute was referred to the Special Purposes Committee of the board and it was agreed that where the AEG or the board was concerned, LHCs should be consulted before the AEG made its decision, or final recommendation to the board. Whenever the AEG consulted LHCs, board members should also be informed by being sent the appropriate papers so that members would not be denied knowledge about matters on which LHCs were being consulted.

Relationships between LHCs within an area varied between Alpha and Beta. In Alpha, regular quarterly meetings were held of Chairmen, Vice-Chairmen and Secretaries of LHCs, when matters of common interest were discussed on an informal basis in addition to the consideration of services covering an area wider than that of any one LHC. In Beta, there was no cooperation between the two LHCs, despite attempts by one of the Councils to bring it about.

Responses from health boards to the questionnaire when asked about the value of LHCs were mixed. The general feeling was that such bodies were useful, although it was too early to be more specific. One board replied that given the drastic reduction of board and committee members after reorganisation, something had to replace them. However, it was agreed that LHCs took up a great deal of administrative and professional time. This view was shared by another board:

Quite frankly their (ie LHCs) contribution has
been pretty limited and in a number of cases they have diverted staff away from doing more important things. I think that over the years a number of them will fade away and their enthusiasm will dim. If they were to be disposed with altogether it would make little difference to the Health Service.

Another board also thought that LHCs, while having good links with the public, were demanding on health board officer resources and could cause delays in decision-making. A fourth board claimed that the relationship between the board and LHCs had not been tested because of the non-contentious nature of the activities up to that time. The existence of Councils was, however, considered to be of value as they were a useful sounding board, and they kept abreast of public opinion, informing the board accordingly.

9.5 Comment
The professional/consumer advisory machinery stands apart from the formal management structure. This, and the fact that they share a common aim, namely, to influence health boards in order to bring about desired changes, or to prevent change from occurring, is about all that service providers and consumers have in common. On most issues their interests may be expected to diverge. (24)

It is not possible, at this stage, to say conclusively whose influence is greater - that of providers, or that of consumers. However, some preliminary observations can be made. It would appear from available evidence (including LHC annual reports) that, with several notable exceptions, LHCs, by their very nature, are only capable of performing a peripheral role. (25) They in no way fundamentally alter
the conclusion that by and large consumers have always been weak in the NHS. This weakness is institutionalised since 'a large portion of (LHC's) membership is appointed by health boards, the very bodies whose policies they are to keep under review'. (26) In a major survey of CHCs in England, Klein and Lewis (27) argue that the proposition that the presence of local authority members on NHS bodies (including CHCs) can be equated with democracy - the most promiscuous word in the world of public affairs - is questionable. It rests on the extremely dubious assumption that the very fact of election is a sort of holy oil of representative legitimacy: that someone elected to serve on one specific body thereby acquires a universal credit card which allows him or her to represent the community in a totally different capacity.

The overall weakness of public involvement in health care decision-making does not mean that professional advisory committees have greater influence. The professions vary in their ability to influence decisions. Although the medical profession has always been able to exert pressure, while other groups, like paramedics, are only just beginning to organise themselves, even the MAS is not without its difficulties. In discussing their role in the MAS, the almost unanimously held complaint among committee members was of the increasing amount of time taken up by committee work. Time lost from clinical work was considerable, yet it was rare to find powers to act firmly delegated to chairmen, or other individuals, or small groups. Doctors were reluctant to see their influence as individuals reduced in any way.

All advisory committees, including the MAS, seem a little unsure of their proper function and remit. The committees
are all expected to take a broad view of health planning and its management and not to be over-influenced in their advice by parochial or vested interests. In practice, this is not such an easy task. Members have also to be aware that their role is advisory but that advice, even when given responsibly, may not necessarily, for a variety of reasons, be acted upon. It should be noted, however, that those providing services are not wholly dependent upon their advisory structure to represent their interests. There are professional officers to perform this task and, in addition, there are board members with professional backgrounds who may be expected on occasion, despite their remit to act as individuals and not as representatives, to be sympathetic to those professions of which they are members.

Despite the problems facing the professional advisory structure, by comparison LHCs have a much tougher task. They are not so much unsure of their role as unsure of how to fulfil it; they walk a tightrope in their efforts to bridge gaps between the public and the management of the NHS. This, as has been said, is 'a delicate arrangement' in which 'their independence will always be at risk, as will their power'.(28)

The last three chapters (ie Chapters 7 to 9) have been concerned with providing descriptions of the three main groups of decision actors (ie policy triad) in Alpha and Beta involved in the decision process which forms the focus of later chapters. The description of the policy triad is in fulfilment of the terms of the frame of refer-
ence outlined in Chapter 4. The purpose of this frame of reference, which has five foci, is to structure the environment under observation. The first two foci have been the subject of the last three chapters: (1) the characteristics of the unit of decision (ie the major participants); and (2) the elements of the organisational context in which a decision takes place (ie relationships among members of the decision unit, and the extent to which there are formal rules and procedures that guide their deliberations). The remaining three foci are the subject of subsequent chapters.
The discussion in the next two chapters on the allocation of DF will appear more meaningful if some background on the financial system operating in health boards is provided, with particular emphasis on revenue funds and development monies. This is the aim of the present chapter.

The NHS is one of the largest British organisations with expenditure in 1978/79 in excess of £8000 million (about £800 million in Scotland), and with about one million employees on the payroll. Not only is the NHS Britain's biggest employer, but it is also the tenth largest employer in the world. Presumably such a scale of operation accounts for numerous references to the NHS as a 'business', the implication clearly being that in some respects there is little to distinguish the NHS from large industrial conglomerates like ICI or GEC.

The total cost of services provided by health boards in Scotland is covered by an annual allocation determined by the Scottish Office, with the exception of the cost of the family practitioner services which are not subject to any form of budgetary constraint (ie they are largely 'demand determined'). The mechanism for financing the health service has been through the annual submission, for approval by Parliament, of the supply estimates. The estimates for the Scottish Health Service are put forward by the SHHD, independently of, but simultaneously with, the estimates for England and Wales.
Although health boards are in theory free to allocate their total revenue budgets as they wish, in practice there are constraints on this freedom. In the first place, the duties and responsibilities of health boards are decided by statute and this limits the purposes for which expenditure can be incurred. There are also numerous informal pressures.\(^1\) Within health boards discretion over allocations is normally confined to the DF at their disposal and boards are free to decide upon detailed disbursements, eg which categories of staff require expansion: whether, for instance, maternity services should be upgraded, or services for the elderly improved, and so on.

Separate allocations of finance are made to health boards for capital and revenue purposes and all proposals for expenditure have to recognise this important distinction. For present purposes, capital allocations can be omitted from the following discussion which concentrates on revenue funds of a recurring nature (ie expenditure on staff).

### 10.1  Arrangements for Allocation of Resources

It is important to emphasise, in the face of arguments suggesting that the NHS is an overwhelmingly centralised, bureaucratic system, that expenditure of the bulk of the funds available for health is controlled by the field health authorities (see Diagram 7).\(^2\) The SHHD's report for 1977\(^3\) on health services in Scotland states that 'the deployment of revenue resources in detail is largely determined by the decisions of individual health boards in that over 90% of the revenue monies available for running health
Source: SHHD, Scottish Health Authorities Revenue Equalisation (SHARE). HMSO, Edinburgh, 1977, p.4
and community services are distributed to them'. Most of the funds retained by the Department for national services relate to the needs of the CSA, in providing supporting services such as the Ambulance and Blood Transfusion Services. Over the research period, money was also retained to cover the cost of commissioning major capital schemes, the actual costs being determined in consultation with health boards. However, the SHARE\textsuperscript{(4)} report on the need to equalise resource-allocation between health authorities (the Scottish counterpart of RAWP\textsuperscript{(5)}) recommends that the present method of funding revenue consequences of capital schemes should be superseded and new arrangements are to be introduced. The remainder of the money was allocated to boards on the basis of the previous year's expenditure plus new money which was distributed, as far as hospital revenue was concerned, according to a formula which gave weight to the main factors which attracted expenditure and, as far as the community was concerned, according to population. The SHARE\textsuperscript{(6)} report notes that health boards have 'considerable discretion to decide for themselves how to spend the money which they receive'. Earmarking of funds for specific objectives does not occur, in part because attempts at earmarking have failed in the past.

The present resource allocation system has two main features. First, it distributes the overwhelming proportion of the funds available on the same pattern as in the previous year (ie historically). Only the new money each year is subject to a formula the purpose of which is to
alter the pattern of resources. Having received this new money, health boards are then free to spend it more or less as they wish. Second, even the limited amount of new resources which are available for altering the pattern of distribution are dominated by the size of the hospital allocation and the weighting for that allocation predominantly reflects the location and number of existing hospital beds (hence the dissatisfaction with the formula).

About 70% of the total expenditure on the health service in Scotland is for current expenditure on health and community services. Revenue expenditure covers the costs of services and assets which are generated in the current year, which include the remuneration of medical, nursing, paramedical, ancillary and administrative staff; the cost of goods and services needed to provide residential care for patients; the cost of drugs, appliances, fuel and replacement of equipment and maintenance of buildings. Wages and salaries come under the heading of recurring revenue expenditure and the other items come under the heading of non-recurring revenue expenditure. The case study is concerned primarily with the former.

What is significant about the entire system of resource allocation, which is only now being questioned as a result of RAWP (England) and SHARE (Scotland), is its historical basis - the previous year's allocation determines the current year's allocation. Gentle and Forsythe (7) acknowledge that revenue has traditionally been allocated to health authorities largely in proportion to 1948 alloca-
Likewise, the interim report of the SHHD's Working Party on Revenue Resource Allocation \( ^8 \) notes that 'there was no conscious effort during this period (ie from 1948 to the present) to effect redistribution of funds as between RHBS. Nevertheless there was continual tension (which still exists in the relationship between the centre and health authorities) as to whether there should be a greater earmarking of funds for various purposes, or whether boards should be allocated the maximum available money to meet local needs as they, and not the central government, thought best. \( ^9 \) The decisive argument in favour of the latter approach was, the interim report suggests, \( ^{10} \)'that earmarked funds often remained unspent because there was no way of transferring them to other purposes quickly enough to enable the total ... allocation of the board to be used by the end of the financial year'.

Although there is still concern at the persistence of uneven patterns of expenditure, and despite national policy guidelines which favour a shift of resources from acute services to services for the chronic sick and the mentally ill, earmarking is not seen as a solution to these imbalances. Instead, the intention (as outlined in \textit{RAWP} and \textit{SHARE}) is to shift the pattern by moving funds in the direction of the authorities/boards with the greater needs (the definition of 'need' being one of the more thorny of the problems tackled in \textit{RAWP} and \textit{SHARE}).

The implications of this shift, planned to take effect over a ten year period, need not be dealt with here. Suffice to say that the Secretary of State has decided that
gradual implementation of the SHARE report should proceed in 1978-79, and, if it is successful, all revenue funds will be allocated to health boards according to a new formula, and not as previously only the 'growth monies'. This will result in a break with historical patterns of resource allocation in the NHS. As has been pointed out, the major change of emphasis in SHARE as compared with the previous method of distributing resources to the areas is that the sole basis for allocation is what the different areas need. Previously - and illogically - the basis of allocation was heavily influenced by what the area had by way of health care facilities. Historical inertia modified only by the loudest voice is no way to determine such an important matter as the fair distribution of health care expenditures. (11)

Whereas the major funds for capital schemes are controlled directly by the SHHD, the development allocation given to health boards on revenue account is granted on the basis of a formula. Each board is given a particular slice of the cake and it is up to that board to decide how best to divide its share. RAWP and SHARE are concerned with whether the national development cake is being divided most equitably between the health authorities; they are not concerned with the purposes upon which boards spend their allocations.

A constraint on the freedom of health boards to allocate resources, which has nothing to do with the problem of central interference, was that, until very recently, revenue allocations were fixed in that they had to be used in the particular financial year for which they were provided. This method of financing gave rise to criticism that it
produced year-end spending sprees, or 'Christmas handouts'. However, a limited degree of flexibility in the use of fixed financial allocations has been introduced which has made it possible to carry forward small unspent balances from one financial year to the next (up to 1%). This has not eliminated the 'Christmas handout' syndrome although it has reduced its occurrence and the size of the sums of money involved.

The so-called 'Christmas handout' exists for several reasons, most of them associated with defective budgetary control. To a large extent the central Department is to blame since it frequently allocates additional monies to health boards late in the financial year. As a Treasurer remarked,

you've no way of knowing what there is in the pipeline and you try and spend it in the most meaningful way possible. It's a bit of a sin for a health board Treasurer to be underspent. You get more thanks if you're £10,000 over than £1 under (your allocation) - you mustn't be underspent. Quite rightly so because (it indicates that) you've not used the money you've been given for the benefit of the health board to the best of your ability. You've got to put on your national goodhousekeeping hat and say 'am I using the country's money wisely in authorising this expenditure?' which perhaps towards the end of the year tends to be on luxury items rather than on the essential ones. We hope this will happen less and less. We were 0.2% overspent last year which was achieved to a certain extent because we took a risk early on in the year (October). (We thought) 'we can spend another £100,000 on equipment - let's do it now rather than wait until Christmas, when there is less meaningful purchasing'. It paid off for us. We were able to look forward on reasonably accurate figures to what our expenditure heads were going to be.

The Treasurer believed that you could 'never do away com-
pletely with the Christmas handout until such time as you allow carry forwards into future years'. As noted above, such an arrangement, albeit on a small scale, is now operating.

10.2 Illusion of Central Control

Public expenditure on the NHS, although globally determined, is at the end of the day, and with some important exceptions (eg approval for consultant appointments), broadly used to purchase resources in the fulfilment of priorities determined locally. Although health boards can dispose of development monies according to their own priorities, occasionally the initiative for new developments in the health service may come from the centre. The decision to redeploy resources from acute services to the 'Cinderella' sectors of the NHS provides one example of this practice. The discretion, therefore, of field health authorities to distribute their development monies according to their own wishes is to some extent circumscribed by central government policy initiatives. However, in the main, as Levitt(12) notes, the DHSS (and the SHHD in fewer cases)maintains 'that only ... broad and long-term priorities can be decided centrally - it is at local level that the details of resource allocation are really determined'. Brown(13) goes further and argues that 'most initiatives come from the grass roots - from the desire of people at the point of delivery for developments that would make their own work more useful, interesting, or satisfying'. Elsewhere, Brown(14) claims that the directive posture assumed by the DHSS has little substance to it,
at least if one is to judge by available evidence. For instance, in explaining the differences between the DHSS' priorities document in 1976, with its clear sense of direction, and its successor in 1977, The Way Forward, Brown suggests that 'the year 1976-77 had been spent in learning not only what was unattainable because it was unrealistic, but also what was unattainable because it was not acceptable to the health authorities ...' (emphasis added).

Field health authorities are not miniature government departments. They use discretion and possess quite considerable autonomy. It is not possible to run them on the basis of 'highly detailed estimates under which practically all of their expenditure was earmarked for certain purposes'.

Consequently,

> there had to be established a system whereby a very high degree of responsibility was delegated to boards for developing their own services within the overall limits of financial allocation made to them which was in any case seen to be desirable on policy grounds'.

A system was evolved during the 1950s which met this requirement for independence. Each RHB received automatically the previous year's allocation, none of which was earmarked. The new money (development funds) to be handed out, the difference between the amount that the government was prepared to put into the hospital service in the forthcoming year over and above that which had been put in in the current year, was subject to a considerable amount of earmarking. The main items were the costs of capital schemes and the money allocated to sectors in line with national policy (eg additional funds for mental
hospitals in an attempt to improve conditions). After these earmarked items had been met (and they amounted in a typical year to about 2.0% of the total development money available) the remainder of the development money was distributed according to the total number of staffed beds available to each board. This was the crude allocation formula adopted. Boards were free to spend this money according to their own priorities. Outside the field of major capital expenditures (where central sanction is required for new schemes), central influence is largely geared to dealing with classes of local issues rather than with specific local issues. In short, most central control is 'contextuating' rather than 'prescriptive' - central government is primarily concerned with setting contexts for local operations through formulating generic policy positions.\(^{(17)}\)

Tension can arise over how the planning of the NHS may be best organised. There are two possible approaches, neither of which is reconcilable with the other, with the result that they coexist uneasily in the NHS. One approach emphasises a centralist mode of operation in policy-making and resource-allocation, the other emphasises a localist mode. This dichotomy between centre and periphery is more apparent in England than in Scotland as illustrated by the different approaches to planning. When Glennerster\(^{(18)}\) writes that 'what we ... see emerging for the NHS is the most managerial and the most hierarchical of planning systems we have encountered either in America or the UK', it is the DHSS (ie English) model he has in
Whereas the role of the DHSS since reorganisation has moved in the direction of greater central intervention in the planning of health services, \(^{(19)}\) in Scotland the relationship between the SHHD and the fifteen health boards has changed little as far as the hospital service is concerned (see below). Watkin\(^{(20)}\) is quite clear about the implications of the DHSS planning system for the NHS. 'To emphasise what a powerful instrument of central control the planning system is, let me point out that before reorganisation the powers of the DHSS to control what happened at the periphery were limited ... '. These weak controls consisted of a system of budgetary control 'which some authorities managed to manipulate'; circulars which might be ignored; direct instructions to health authorities which were seldom used; approval of capital building programme; and regulations enforcing the application of national agreements on salaries and conditions of service.

Senior civil servants in the SHHD were anxious in interviews to emphasise the different relationship which exists between centre and periphery in the Scottish Health Service since reorganisation. Essentially, the relationship closely resembles that which existed with the former five RHBs. Even the planning arrangements at the centre in Scotland involve health boards directly through the machinery of the Planning Council. In its report for 1976, \(^{(21)}\) the Council, in a comment on how planning could be improved, asserts that 'decentralised decision-making by health boards was preferable to centralised decision-making' and 'that the planning process should be as simple and flexible as
possible ... '. As far as the statutory relationship between the SHHD and the health boards goes, this is no different now from what it was before reorganisation.

The relationship between the centre and the periphery is one which, to some extent, continually redefines itself according to changing circumstances. There seems little doubt that when the economic recession began shortly after reorganisation of the NHS, the SHHD did begin to take more interest in health board affairs in its attempt to monitor public spending. But this change of attitude on the part of the Department was not the outcome of reorganisation, although it happened to coincide with it. Strained relationships also developed between centre and periphery elsewhere in the public sector, for example, in local government.

But despite the introduction of financial controls in the form of cash limits and other pressures making for a greater degree of central oversight (see below), senior civil servants claimed that the Department had endeavoured to maintain the independence of health boards. The reality of this was evident in the policy of refraining from earmarking sums of money to be spent on particular areas of health care or on special projects. Apart from an oversight of the capital expenditure of health boards (which has always existed), the SHHD has not interfered directly in board's revenue allocations beyond laying down cash limits to control spending. However, in England, as has been noted and as Scottish civil servants were quick
to point out, the DHSS did on occasion earmark funds being allocated to health authorities. The joint planning and joint financing arrangements introduced between health and local authorities in England from 1976-77 by the DHSS\(^{(22)}\) are an excellent illustration of the current trend towards greater central direction. Arrangements of this kind do not exist in Scotland at present.

The very nature of the structure of the NHS (and, indeed, of public services generally), and the method by which it is financed from the centre, makes the likelihood of a tension-free relationship between centre and periphery remote. As a civil servant explained, the NHS comprises a plurality of field authorities representing the public interest, spending large sums of money, and operating with considerable independence. But because all these authorities are answerable to a political chief accountable to Parliament, the Department has to involve itself in matters involving resources, such as changes of use for hospitals, or hospital closures; because these are highly contentious issues it is important that the Department should be able to explain what is happening in the event of parliamentary questions being asked. It is also essential that the Department remain accountable to Parliament through the Secretary of State for the way in which funds voted for the NHS are spent.

While conceding the existence of these tensions, civil servants in the SHHD argued that it was not correct to see the reorganisation of the Scottish Health Service as an attempt by the Department to strengthen its hand over
health boards. The service operated on the basis of a partnership between the Department and the health boards which was altogether more flexible than the elaborate annual planning cycle which was a key element in the English arrangements. According to Watkin,\(^{(23)}\) 'the new planning system (in England) will bring all new developments under the same kind of control as previously existed for capital works'. The scale of operations alone in Scotland makes it feasible to think in less centralist terms. Another reason for Scotland pursuing a different approach to planning is the lack of a strong management bias which permeated the English proposals for reorganisation.\(^{(24)}\) Moreover, to quote Watkin\(^{(25)}\) again,

> it is a paradox that the NHS is too vast an organisation to be managed effectively from the centre, yet at the same time its vastness and its social and economic significance generate irresistible pressures for central control.

These pressures are more in evidence in England because the scale of operations is much greater than in Scotland and the DHSS feels it necessary to overarch the field authorities in a way which is not thought to be relevant in Scotland.

Not surprisingly, perhaps, officers at health board level do not fully share the civil servants' interpretation of the relationship between the SHHD and field authorities. Many of those working in health boards are only too keen to find fault with the centre and blame it for faults in the service (the NHS, of course, is not the only organisation where such sentiments abound; moreover, these views
are replicated within health boards where, for example, district officers accuse area officers of mismanagement and interference, etc). One Treasurer, however, did not think that the SHHD had become any more interventionist since reorganisation. He claimed that 'health boards are still autonomous and the Department leaves boards to get on with it, provided they remain within cash limits'. However, the Treasurer, and other officers, agreed that in an economic recession it was inevitable that the Department would watch the financial situation more closely since it was responsible to the Treasury which, in turn, was responsible to Parliament. But this did not represent a change of Departmental policy towards health boards. According to the Treasurer, 'had the economic crisis developed five years ago the Department would have acted in the same way ... '.

The chief intrusion into health boards' autonomy was national decisions pre-empting board ones (ie decisions boards were obliged to implement although they had no part to play in the making of the decisions). Invariably, these were a product of resource constraints; as another Treasurer commented in connection with two such decisions, namely, the junior doctors' overtime pay award, and the establishment of a family planning service, these national decisions assume greater significance at a time when development monies are very small, and create difficulty. In a normal period these decisions would not take up an undue proportion of funds available. The area of discretion would be left largely with the individual health board to determine its priorities within the development funds available.
Civil servants were aware of health board officers' views on these matters. Referring specifically to family planning services, one civil servant agreed that health boards are annoyed at the pre-emption of their resources in the family planning field. This was an intrusive act of government. We managed to bale health boards out in Year 1 (the service was phased in over two years) and assisted some boards 'over the hump'. But family planning was an aberration. In a normal year expenditure on family planning would have been masked because development fund allocations to health boards would have been higher.

10.3 Comment
The budgetary process and the relationship between centre (SHHD) and periphery (health boards) are virtually inseparable. The process by which resources are allocated to boards, and the extent to which the centre is involved in the use of these resources, reveals the amount of discretion boards possess to pursue their own priorities as determined at the local level. The main theme to emerge from the foregoing discussion is that health boards have, in theory, a considerable amount of autonomy to allocate monies, although in times of economic uncertainty, when there is concern about escalating public expenditure, the centre can be expected, quite naturally in the circumstances, to intervene more directly in the affairs of health authorities. This process has gone further in England than in Scotland, although the tendency for greater central interference has always been more apparent in England through the earmarking of funds allocated to health authorities. Central direction has assumed a new
dimension in England for two main reasons: (1) concern over resource use in the NHS has always been more pronounced, probably because of the size of the service in England; and (2) the model adopted for the reorganised service has placed more emphasis on the role of the centre in priority-setting.

The obstacles preventing the development of a mutually acceptable relationship between centre and periphery in the NHS stem largely from the fact that the structure rests on an attempt to reconcile the irreconcilable. The twin features of the structure, centralism and localism, which were mentioned earlier, are dichotomous. The dilemma at the root of the dichotomy between centre and periphery is that if, on the one hand, health authorities are to be left to choose how they distribute their funds, then national priorities run the risk of becoming little more than rhetorical exercises. But if, on the other hand, central government is to determine priorities then local initiatives and autonomy are, at the very least, severely curtailed. As an observer of the DHSS planning system for the NHS in England has written: (26) 'the unknown in the question remains: to what extent will local health authorities be free to interpret in their own way the policy guidelines offered by the Department'?

In Scotland, too, the interplay between centre and periphery is a recurring theme in any analysis of resource-allocation, and later chapters return to it when some of the external constraints impinging on the allocation of DF
are examined. However, while health boards may possess a degree of autonomy to allocate resources (particularly DF) and decide priorities, their ability in practice to enjoy this freedom is circumscribed by numerous internal constraints which can have a more potent impact on the decision process within health boards than attempts by the centre to impose its will. The next three chapters are devoted to an exploration of some of these constraints as they operated in Alpha and Beta.
Chapter 11

DETERMINATION OF POLICY:

DEVELOPMENT FUND ALLOCATIONS (YEAR 1)

In this chapter and the next, an attempt is made to relate the sequence of events which occurred in the process of allocating DF during the period of observation in Alpha and Beta over two years (see Diagrams 8 and 9). Observations from both boards are interwoven in order to illustrate the underlying similarity of approach. The descriptive material seeks neither to compare or contrast Alpha with Beta in any systematic way, nor to compare or contrast the allocation process in Year 1 with that in Year 2. The narrative is a cumulative compilation of the evidence gleaned from both boards which, hopefully, represents a reasonably typical allocation process for DF. Most of the data are derived from field work undertaken in Alpha, since this board was observed over a longer period. Data obtained from Beta constitute a check on the findings which emerged from Alpha.

Recalling the frame of reference outlined in Chapter 4, Chapters 7 to 9 were organised around the first two foci: (1) the characteristics of the unit of decision, and (2) the elements of the organisational context in which a decision takes place. This chapter and Chapters 12 and 13 are structured round the remaining three foci: (3) the characteristics of the setting in which the unit of decision must operate; (4) the origin of the decision-making situation; and (5) the pattern of motivations character-
DIAGRAM 8 Stages of the Development Fund Allocation Process

SECTOR ADMINISTRATORS ➔ COLLECT STAFF REQUIREMENTS FROM HEADS OF DEPARTMENTS - DOCTORS, NURSES, PARAMEDICALS, ANCILLARY STAFF

DEG ➔ RECEIVE REQUESTS FROM SECTOR ADMINISTRATORS. MAKE UP LISTS, WITH SOME PRIORITY MARKING

AEG ➔ RECEIVE LISTS FROM DISTRICTS. DECIDE HOW TO SPLIT REVENUE BETWEEN DISTRICTS AND BETWEEN SERVICES. LIST PRIORITIES FOR DISTRICTS TO CONSIDER

DEG ➔ RECEIVE COMMENTS FROM AEG WITH AMOUNTS ALLOCATED. GO THROUGH LISTS SELECTING IMPORTANT ITEMS UP TO AMOUNT ALLOCATED

AEG ➔ RECEIVE FINAL LISTS FROM DISTRICTS. CONSIDER HOW TO PRESENT THESE TO ADVISORY COMMITTEES

PROFESSIONAL ADVISORY COMMITTEES ➔ LISTS ARRIVE FROM AEG FOR COMMENTS

AEG ➔ LISTS RECEIVED BY AEG WITH COMMENTS FROM ADVISORY COMMITTEES

POLICY AND RESOURCES COMMITTEE ➔ POLICY AND RESOURCES COMMITTEE EXAMINES DEVELOPMENT FUND ALLOCATIONS

HEALTH BOARD ➔ TAKES NOTE OF DEVELOPMENT FUND ALLOCATIONS

IMPLEMENTATION

NOTE: The Diagram is based on events in Alpha in Year 1.
**Diagram 9**  
**Annual Cycle for Allocation of Development Funds**

<table>
<thead>
<tr>
<th>Month</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN</td>
<td>DISTRICTS SUBMIT DEVELOPMENT LISTS TO AREA</td>
</tr>
<tr>
<td>FEB</td>
<td>AEG CONSIDERS SUBMISSIONS FROM DISTRICTS</td>
</tr>
<tr>
<td></td>
<td>SHED ALLOCATES FUNDS TO HEALTH BOARD</td>
</tr>
<tr>
<td>MAR</td>
<td>DISTRICTS RECONSIDER LISTS WITH AREA'S PRIORITIES</td>
</tr>
<tr>
<td>APR</td>
<td>AEG EXAMINES DISTRICT SUBMISSIONS</td>
</tr>
<tr>
<td></td>
<td>ADVISORY COMMITTEE COMMENT ON LISTS</td>
</tr>
<tr>
<td>MAY</td>
<td>AREA PREPARES PROPOSALS FOR BOARD</td>
</tr>
<tr>
<td>JUN</td>
<td>APPROVED PROGRAMME EXECUTION</td>
</tr>
<tr>
<td>JUL</td>
<td></td>
</tr>
<tr>
<td>AUG</td>
<td></td>
</tr>
<tr>
<td>SEP</td>
<td>DEVELOPMENT LISTS BEGIN TO BE MADE UP BY DISTRICTS FOR NEXT FINANCIAL YEAR</td>
</tr>
<tr>
<td>OCT</td>
<td></td>
</tr>
<tr>
<td>NOV</td>
<td></td>
</tr>
<tr>
<td>DEC</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** The Diagram is based on the timetable established by Alpha in Year 1. Beta followed a similar timetable.
ising the decision process.

As mentioned in Chapter 6, the original intention was to follow through the allocation process over two years in order to improve the reliability of the observations and to discover how stable the allocation process was (ie to what extent it followed a similar pattern from one year to the next). In the event, this particular objective could not be fulfilled because of developments in the economic climate which caused quite dramatic reductions in the growth monies allocated to the NHS. For Year 2, the allocation of DF (revenue) to health boards was in the region of 1% compared with 3½% in the preceding financial year. Consequently, neither Alpha nor Beta were greatly concerned with allocating funds, since these did not amount to very much. Their energies were primarily devoted to identifying savings to enable essential developments to be implemented through a 'better' use of existing resources. This strategy, as revealed in Chapters 2 and 3, was one of the aims of reorganisation, and it was a major reason for the emphasis placed upon an improved managerial capability. Significantly, as subsequent sections show, it did not feature prominently in the decision-making process until administrators were forced by external events to adopt it. Despite this upset in the original research plan, the decision process in Year 2 proved to be of great interest. The suddenness of the economic 'crisis', the unexpected severity of cuts in the growth rate of the health service budget, the need for decision-makers to adjust quite
rapidly to a completely different situation from the one to which they had become accustomed, and the adoption of a new approach to developments, all illustrated the wide variety of constraints and fluctuations, both external and internal, to which NHS administrators are subject. In such a shifting, unpredictable environment, it is easy to appreciate why planning drift occurs.

It is important to stress that the unexpected events which occurred in Year 2 do not invalidate the research project. It has already been pointed out that the research is primarily concerned with priorities and these have to be selected regardless of whether funds are plentiful or in short supply. If funds are scarce then the decisions to be taken on priorities are that much tougher. What does change, however, is the environment within which these decisions on priorities are taken. The atmosphere and sequence of events will tend to differ from the practices and routines established during normal growth periods. Evidence obtained from the two health boards in Year 2 supports this proposition.

Observing the efforts of both boards to face up to the uncertainties and challenges that lay ahead of them presented a unique opportunity to assess the extent to which the resource 'crisis' represented a chance to bring about long-awaited changes in how various groups within the NHS bargained for additional resources. If incrementalist theories of decision-making have any relevance in this context, then change (taking this to include the reinforcement of existing services through improvements and/or expan-
sions), if there was any at all, would be minimal; on the other hand, a crisis situation (if, indeed, that was what it was) might enforce more dramatic departures from the existing base-line which would suggest that perhaps incrementalism only applied to decision-making in periods of 'normalcy', whereas in times of crisis more significant innovations were conceivable, if exceptional.

These possibilities, along with an analysis of the description of the allocation process in Years 1 and 2 which seeks to identify the major constraints which faced decision-makers, and the strategies they adopted to make sense of their often unpredictable and incoherent environment, are explored in Chapter 13.

11.1 Development Lists

In Year 1 the allocation process began with the preparation of development lists. In mid-January, the Treasurer (Alpha) sent a memorandum to the two DFOs requesting them to submit details of schemes and developments which the districts wished to be considered by the AEG when it allocated available funds. At this time, Alpha did not know what the DF would amount to since the SHHD had not notified the board of its total allocation. The districts were asked to include on special forms as much detail as possible about each request to assist the AEG in their deliberations. The forms for non-capital developments (which included increases in staffing at hospitals or in the community, and increases in the number of outpatient sessions requiring additional nursing, medical, ancillary
and secretarial staff) asked for a description of, and need for, each development (in priority order), the earliest start date for new staff, staff numbers by grade and the full year cost of each development. The lists were to be sent to the Treasurer by the end of the first week in February, which gave the districts around three weeks to comply with the AEG's wishes.

In compiling their lists, both districts referred to their stock of requests for funds which had been collected over the year; additional requests were obtained from sector administrators, heads of departments, consultants, and so on. Sometimes approaches by consultants, and others, would be made to the districts direct, or, on occasion, to an area officer who was then obliged to refer the request to the appropriate district officer. All requests made through these channels were added to the list.

Placing the submissions in order of priority was no easy task (see Table 11.1). One DFO (district 'A'), on returning the completed forms, explained in a memo to the Treasurer that

the DEG considered placing them (ie developments) in strict priority order but found it difficult to do so, in the short time available, and in the absence of both detailed background information and comparative criteria to make an objective evaluation. It was agreed, however, that certain requests deserved to be considered before others and those items marked with an A on the list represent the banding together of our first line priorities without attempting to place them in order of preference.

Such supporting evidence as was available accompanied the development lists. The other DEG (district 'B') in Alpha faced remarkably similar difficulties, although it adopted a slightly different method of placing requests in order
### TABLE 1

<table>
<thead>
<tr>
<th>District</th>
<th>Total Submissions</th>
<th>Priority Categorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£820,930</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£458,480</td>
<td>£362,450</td>
</tr>
<tr>
<td></td>
<td>£220,575</td>
<td>£135,875</td>
</tr>
<tr>
<td></td>
<td>£16,100</td>
<td>£6,000</td>
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#### Analysis showing values of priorities in submissions

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital</th>
<th>Community</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1981</td>
<td>22,100</td>
<td>0</td>
<td>22,100</td>
</tr>
<tr>
<td>1982</td>
<td>220,575</td>
<td>135,875</td>
<td>356,450</td>
</tr>
<tr>
<td>1983</td>
<td>458,480</td>
<td>362,450</td>
<td>820,930</td>
</tr>
</tbody>
</table>

Note: District B categorised its priorities in greater detail than district A.

2. Make up of submissions in Total

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital</th>
<th>Community</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
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<td>1981</td>
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<td>0</td>
<td>22,100</td>
</tr>
<tr>
<td>1982</td>
<td>220,575</td>
<td>135,875</td>
<td>356,450</td>
</tr>
<tr>
<td>1983</td>
<td>458,480</td>
<td>362,450</td>
<td>820,930</td>
</tr>
</tbody>
</table>

3. Total of submissions

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital</th>
<th>Community</th>
<th>Total</th>
</tr>
</thead>
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<td>1980</td>
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<tr>
<td>1982</td>
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<td>356,450</td>
</tr>
<tr>
<td>1983</td>
<td>458,480</td>
<td>362,450</td>
<td>820,930</td>
</tr>
</tbody>
</table>

Note: District B categorised its priorities in greater detail than district A.
of priority. All submissions were considered by the DEG and given a priority A, B, or C. But, according to the DFO's memo, they 'are not necessarily shown in priority order within each letter'. Moreover, 'due to the short time that was available to complete these forms, it has not been possible to consider each request as fully as one would have wished and also to provide the complete details of the need'. Very little supporting evidence accompanied this district's development lists.

The amount of data submitted to the AEG for consideration was quite considerable. District 'A' submitted 71 pages of developments, with each request listed on a separate form. The composition of the requests ranged widely, and included submissions from the hospital service for senior house officers, medical secretaries, technicians, pharmacists, medical records staff, porters/drivers, physiotherapists, domestic staff, etc; in the community service, requests were submitted for chiropodists, physiotherapists, dental technicians, midwives, health visitors, nurses for GP attachments, etc. In district 'A', there were 28 requests for the hospital service, 21 for community developments, 19 for the area laboratory service, 2 for developments affecting the whole district, and 1 for the school of midwifery. The requests totalled nearly £405,000 (ie as it happened, close to the total sum available to Alpha for developments), and of this £220,575 was for community developments, £87,735 for the area laboratory service, £80,035 for the hospital service, £15,650 for district developments, and £960 for the midwifery school (totalling
£184,000 under 'Hospital' in Table 11.1). Of a total of 71 developments, supporting information was provided for 54 of them (see below).

In district 'B', the development requests totalled 56, 20 of which were for community services. The remainder, including 3 which were related to the nursing establishment, were for the hospital service. The requests totalled just under £394,000, of which £258,000 was accounted for by hospital developments and £135,875 by community developments. Very brief, and often general, supporting data accompanied the requests (see below).

From this rudimentary breakdown of the districts' development lists, it can be seen that district 'A' seemed to be placing a greater priority on community services than district 'B'.

In addition to the districts' requests for DF, the area had also prepared a short list of 8 proposals (this was to grow to 15). These were for area-wide functions and included a health education officer, a security officer and 2 registrars. The requests, at this stage, totalled £22,000 approximately (they stood at £53,000 approximately when the final list was prepared).

As noted above, district 'A' supplied a substantial amount of supporting evidence with its requests, most of which took the form of letters or memos from heads of departments and others to district officers or to area officers. It is neither possible, nor necessary, to analyse all these data in systematic fashion, but a flavour of the sort of
evidence that was produced in support of favoured developments may be conveyed. The examples which follow are typical of the cases put forward by interested parties.

1 A request for additional microbiology staff.

The case for this request was presented by a consultant bacteriologist to the CAMO. The arguments given were: (a) the need, as laid down by the Medical Laboratory Technicians' Board, to provide in-service training in medical microbiology. This would require a senior technician to devote half his time to provide training. Training was not possible without additional staff. (b) The increasing pressure which was being applied by technical and secretarial staff for a reduction in the frequency of Saturday working per head. The extra week's holiday per annum to which junior technical staff were entitled, reinforced the need for more technical staff. The request for additional staff ended with a warning that if necessary staffing was not forthcoming restrictions would have to be placed on the service.

2 A request for a senior house officer (geriatric assessment unit).

The case was initially presented to the CAMO and the DFO by a consultant physician in the geriatric service. It was repeated by the Chairman of the Division of Geriatric Medicine who approached the DMO. Finally, the Area Medical Committee accepted the recommendation of the Area Committee of Chairmen that there was a very strong case for a second SHO post in the geriatric assessment unit. This was communicated to the Secretary and to the DA. The need for additional staff arose from the present inadequacies in numbers of junior staff. The junior establishment consisted of 1 Registrar and 1 SHO. The Registrar was unable to perform his prescribed role because of limitations on his time imposed by his ward admission work. This routine activity ought to be the responsibility of an SHO but the existing SHO was already over-burdened with ward work.

3 A request for a senior chiropodist.

The case for this request was presented by a CMS (Mental Health and Geriatrics) in a letter to the DA. The existing senior chiropodist
was unable to cope with the workload and an additional chiropodist was necessary to ease the pressure.

4 A request for medical secretaries.
The case was presented by a former hospital secretary prior to reorganisation. The argument in favour of further staff was that the present establishment of medical secretaries was unable to cope with the increasing workload. 'This has resulted in the quality of work declining which in turn attracts adverse comments from the medical staff'.

5 A request for midwives.
The case was presented by a Principal Nursing Officer to the DFO. This was a 'very essential development because of the lack of midwives employed in the community division'.

6 A request for health visitors.
The case for this request was presented by the DNO to the DFO. Additional staff were required on the basis of an assessment of staffing needs derived from recommendations contained in a SHHD circular issued in September 1972. This recommended a health visitor to a population of 3,000 where there was a highly developed system of attachment to general practice.

District 'B' submitted evidence of a scanty nature. Unlike district 'A', this was not submitted in the form of copies of original letters or memos, but in the form of brief comments which were included on the development request forms. Some examples follow.

1 A request for a senior radiographer.
'Increased demand'.

2 A request for ward housekeepers.
'To relieve nursing staff of non-nursing duties'.

3 A request for a pharmacist.
'To cover additional commitments due to reorganisation of service'.

4 Requests for charge nurses, staff nurses and
enrolled nurses.
'To bring present establishment up to satisfactory level.'

5 Requests for general hospital nursing staff.
'Finance required to meet revised nursing establishment approved by (the former) BoM'.

6 A request for senior chiropodists.
'The care load of the present chiropodists is too high and there is a continuing rise in the number of elderly patients requiring this service'.

A recurrent theme in most, if not all, of the evidence (including the examples cited above) in support of requests for DF was the pressure on existing staff, whether clerical staff or consultants or whatever, which was (or would be) responsible for a poor standard of service. The arguments deployed to justify increases in establishments invariably revolved round increasing workloads, increasing rates of admission, and an inability to perform essential duties because of diversions to other, often menial, tasks. It was clear from much of the evidence that improved conditions for staff (eg longer holidays) had placed additional strains on the provision of services and were a chief cause of requests for further staff to provide the same standard of service. In many cases, the supporting evidence consisted of little more than a persuasive letter from a consultant. In a lesser number of cases, hard, quantitative data accompanied written pleas. For example, in a request for medical secretaries, statistics showing the rate of overtime worked by medical secretaries during a fixed period were included, as were data on inpatient and outpatient statistics over a two-year period in order
to show the increasing pressures under which staff worked. Other evidence cited SHHD circulars setting down staffing norms which health boards were obliged to attain.

A District Personnel Officer (DPO) explained that the process of obtaining requests for DF and compiling development lists was one which reflected

very much what people asked for. We took what they said at face-value and put it on the list. This procedure had its failings. A lot of correspondence went backwards and forwards and a development was either hardly supported at all or there was little information to back it.

The CANO in Beta claimed that the requests for DF amounted to 'a shopping-list of deficiencies and pressure points. We don't have a long-term goal or direction in which we're going'. The examples of requests, given above, illustrate the 'shopping-list' nature of development lists. For further discussion of this point see Chapter 13.

11.2 The Function of the AEG

The first meeting of the AEG to decide upon the allocation of DF was held towards the end of February. Chief officers wanted to allow as much time as possible for implementation of the developments chosen for funding, and this meant determining the allocations as quickly as possible. The meeting was important since its purpose was to consider the general approach to be adopted towards the allocation of DF by the AEG. The Group's task was to formulate a strategy on how to handle the allocation process and to decide upon the part it would play in this. Most urgent was the need to consider how best to deal with the multifarious submissions for DF in terms of the desired
overall direction of services in the area. The meeting was of added significance because it was the first time since reorganisation that the AEG had handled this process. As the Treasurer (Alpha) commented, 'we are all learning as we go along'.

Because the AEG was going through the allocation of DF for the first time, there was a greater tendency, perhaps, for the four members of the Group to concern themselves with quite fundamental issues like, for example, the role of the AEG vis-à-vis the board, the two districts, and the advisory committees. Since the entire procedure lacked precedents (although all the officers could draw on their NHS experience prior to reorganisation, much of which was relevant to the allocation of DF), the Group had to devise a strategy to enable it to operate the allocation process as speedily as possible. The first meeting, and subsequent meetings on the allocation of DF, was chaired by the Treasurer. As mentioned in Chapter 8, the AEG in Beta did not operate in such a flexible way. The Secretary chaired all meetings regardless of the subject matter under discussion.

At the time of this initial meeting, the allocation for the financial year was not officially known. However, it was possible, on the basis of the previous year's allocation, for the Treasurer to estimate what the allocation for developments would be. A sum of around £300,000 for disbursement was arrived at (the actual sum was £421,000). Since total submissions received for DF amounted to £820,930
approximately, obviously, with £421,000 having to be set against £820,930, some potentially awkward choices would be necessary.

In reaching an appropriate strategy for allocating DF, the AEG had to resolve a number of problems. Although these were to some extent technical matters, they had profound policy implications. First, the AEG had to decide whether development monies should be set aside for additional staff under heads of expenditure like medical, nursing, catering, etc, or whether monies should be set aside on a functional basis, namely, for particular services like geriatrics, psychiatry, child health, etc. It was decided that it was not possible at this stage to move to a functional approach. The Programme Planning Groups which had been established in certain areas of health care would assist in a move in this direction in subsequent years, or so it was envisaged. More information was necessary before the adoption of the functional approach could be realised. Moreover, for professional advisory committees it was presumed to be much easier to think subjectively - they were unenthusiastic about a functional approach to development fund allocations. It was far less complicated to look at staffing requirements in terms of additional numbers, for example, six consultants, ten nurses, and so on.

Second, the AEG had to decide what proportion of DF should be spent on the hospital service and what proportion on community services. The choice was between keeping to
the general development rates indicated nationally by the SHHD, and developing one sector (hospital or community) at a faster rate than the other. The AEG decided to conform more or less to the development rates suggested by the Department. National indicators and guidelines would be adopted which, as the AEG stressed, were only guidelines and not policy statements about desirable developments, that is, health boards could vary their allocations and were not beholden to a Departmental line.

Third, a related problem, paralleling the division between hospital and community, was the AEG's stance on the emphasis to be given to curative care on the one hand and preventive care on the other. For example, should prevention be given a greater emphasis through allocations of DF than curative medicine? This was an important decision because it is, in practice, only through DF that a board can change direction or shift the emphasis placed on particular services.\(^{(3)}\) The AEG expressed a hope that at some stage guidance on this matter would be forthcoming from the Planning Council. At this stage, however, both the Secretary and the CANO were strongly in favour of an expansion of community services. To a large extent, the priority to be accorded community services reflected what was fashionable at a national level in terms of the future development of the NHS.\(^{(4)}\) Only the CAMO was wary of stressing the development of community care services in a random fashion. Although sympathising with the view that these should be developed, he wanted to know what specific
developments were planned for the community. Overall, he remained unconvinced that the need in the community service was greater than the need in the hospital service.

In addition to these specific problems, the AEG spent time at the first meeting trying to define an appropriate role for itself in the process of allocating DF. It was largely a matter of deciding to what extent the Group should become involved in detail, and members were divided on the approach they should adopt. On the one hand, the Secretary and CANO favoured as much delegation as possible to the districts while, on the other hand, the Treasurer and CAMO preferred a more interventionist role for the AEG in the allocation of DF. Eventually a compromise was reached upon which all members were agreed, namely, that although the AEG was not in a position to decide priorities between schemes A, B, or C that had been submitted by the districts for consideration by the area, it would issue general guidance on priorities. The main arguments in the discussion are presented here.

It was accepted, though not entirely by two of the chief officers, that the AEG lacked the knowledge necessary to choose between particular developments on other than purely subjective criteria. In any case, as pointed out in Chapter 8, the ability to take a detached view of service needs and priorities was a central function of the AEG. The uncertainty among chief officers as to how they ought to proceed in allocating DF was revealed by the Secretary who thought that although much in the submissions
from the districts for DF was desirable, the real question was the extent to which it was practicable. Perhaps unrealistic demands were being made on limited resources but the AEG was in no position to know whether this was so or not. An example is cited which illustrates some of these difficulties. It concerns a request for an improved laboratory service.

The amount requested for developing laboratory services was £90,000. The Treasurer suggested setting aside a sum of £30,000 (ie 1/3 of the amount requested), and it was decided that new posts would have to be funded as the laboratory service wished with the money allocated to it since the AEG was not in a position to decide priorities. A member of the AEG noted that the laboratory service already received £300,000 and wondered whether it was not one of the services that was developing at a faster rate than other services. Moreover, should it be allowed to continue to develop at a rate of 15%? The Treasurer was unsure whether it lay within the AEG’s power to stop its development since the laboratory service was not susceptible to the controlling influence of the laboratory technicians. It would be necessary to educate clinicians and persuade them to reduce their demands on the laboratory service before actual expenditure on it could be curbed. Since the AEG was reluctant to continue pouring money into the laboratory service, the Treasurer suggested a compromise, namely, that the laboratory should receive an allocation of £20,000. This was after the Secretary had
stated his preference for an allocation of £12,000. It was agreed to refer the matter to the AMC for comment.

This example illustrates three problems which faced the AEG: (1) the inability of the AEG to avoid entering into detailed discussion of particular development requests; (2) the inability of the AEG to become involved in detail in a knowledgeable way when requests were being discussed; and (3) the repercussions that one development can have on other parts of the service, which impose quite severe constraints on the AEG's freedom of manoeuvre, ie the fact that expansion of the laboratory service had little to do with the service itself or with those running it, but with the clinical practices of doctors over whom there was minimal control.

When it attempted to consider the development lists, the AEG was unsure how to proceed with the 'carving up of the cake'. So many imponderables surrounded staffing requests. For example, could staff be obtained? In some specialties, like geriatrics and the mentally ill, this was doubtful. The Secretary did not think that decisions between various staff requests could be made by the AEG. It was a task for the districts since they possessed (or ought to have) the necessary information which would enable these decisions to be made. The AEG did not know the relative priorities, nor did it know the facts or circumstances behind various requests. The districts, he believed, must be allowed to decide priorities.

There was not unanimous agreement over this course of
action. The Treasurer took the view that it was the AEG's job to fund specific developments from the list and he was against giving the districts authority to take these decisions. The AEG should know where the 'shoe is pinching most' and, if it did not, then it was failing in its duty. It was the Group's function to monitor the districts and it was not possible to do this unless the AEG knew what was happening 'on the ground'. At the Treasurer's insistence, therefore, the AEG did attempt to work through the bundles of requests in order to give chief officers an opportunity to give their preliminary reactions. In the light of what has already been said, this proved a difficult task to perform in a meaningful way. To take just one example, two porters were required at one of the hospitals in the area. Doubtless there were good reasons for requesting them but no one on the AEG knew what these were.

What worried the Secretary about the AEG's general ignorance was that priority might be given to some requests about which something was known to the neglect, or exclusion, of other requests when these might be more important. While the Secretary agreed that feedback came from below (ie from district officers and others) in one's own field, it was not possible to make comparisons between requests for different staff because one only possessed information relating to one's own sphere of interest, not to the overall scene. The sort of comment the AEG could usefully make to a district would be of the order that, for example, as regards hospitals X and Y a balance was necessary
between them to avoid one being favoured over the other. It was, the Secretary agreed, essential for the AEG to be made aware of pressures within the service, but in attempting to scrutinise individual appointments in detail, it was on riskier ground. In the position the AEG found itself, it could neither be for nor against a particular staff appointment. All one would be doing, if one had a particular interest in a specialty, would be making sure that it received preferential treatment. This would lead, inevitably, to a tendency to ride 'hobby horses'. Unlike the Secretary, the Treasurer and CAMO believed that riding hobby horses was necessary and, moreover, that officers would be failing in their duty if they did not do so.

Against this, the Secretary argued that while the AEG might get to hear of a crisis situation it was by no means certain that all problems would filter up to the area. He doubted whether it was sufficient, in deciding between individual requests, that a mere feeling for a particular appointment should prevail over all else. At the very least, in deciding whether, say, medical secretaries were more important than surgical assistants, information was necessary for this kind of exercise.

The division of opinion between members of the AEG was finally resolved without endangering the emergence of a consensus. As noted earlier, it was agreed that the AEG should issue general guidance to the districts on the overall provision of services and that it must decide the direction in which the service as a whole should move.
The strategy to be pursued was that development monies would be divided between the two districts, who would review their current development lists, revise them on the basis of the funds available to them and in the light of the AEG's comments on developments it would like to see given priority, and submit these to the AEG.

The first meeting of the AEG has been dwelt on at some length because it raises a number of crucial issues, some of which have already been encountered in previous chapters, especially Chapter 8. A recurrent theme of the meeting was where the balance ought to lie between direction from the centre (ie the AEG), and the degree of latitude to be afforded the periphery (ie the DEGs). A striking observation was the apparent confusion (at a restrained level) within the AEG as to its precise role in the allocation of DF. It was clear from the initial meeting that the AEG's conception of its policy-making role, and its relationship with the two DEGs, remained to be worked out. The various exhortations to be found in the 'Blue Band Circulars' and elsewhere proved to be no substitute for 'muddling through' on the job. The atmosphere within the AEG was one of 'cautious groping', as officers attempted to make the new structure work in a way that was acceptable to everyone even if it was not necessarily in the way that had been intended.

It was interesting to observe at the first meeting the different stances taken by officers. Whereas the Secretary, for example, was for allowing the district officers
the freedom to spend the money as they thought best while the AEG kept an overall balance of services throughout the area, the Treasurer took a more cautious view of the merits of delegation. His concern with finance, budgeting and bookkeeping led him to perceive the AEG's role, to a great extent, as a monitoring and controlling one, which involved keeping the districts' autonomy within well-defined limits.

The second AEG meeting was held about three weeks later. On this occasion, there was less discussion about an appropriate role for the AEG in allocating DF, and much more about how the DF were to be allocated both as between the two districts and the area, and as between the hospital service and the community service. An attempt was also made to establish priorities, or at least to agree on those developments that the AEG considered to be priorities. At this meeting, the involvement of advisory committees and the health board in the allocation process was discussed, and a timetable was fixed for the remainder of the allocation process, which was expected to be completed by early summer.

The factor which more than anything else contributed to a concentration of minds at the meeting was pressure of time. It is not being facile to say that the time factor forces decisions to be made and compromises to be reached when otherwise there could be no decision or, at least, considerable delay. Members of the AEG were concerned that almost half a year would have elapsed before developments approved by the health board would be implemented.
Once funding had been approved, advertisements had to be placed, interviews arranged, and, finally, appointments made. The entire operation was time-consuming.

Most of the discussion at the meeting centred on a paper prepared by the Treasurer, which gave details of the SHHD revenue allocation for Year 1 and the free funds that were available after deducting the running costs of capital schemes, the running costs of non-capital developments, and additional administrative costs arising out of reorganisation. Of the £421,000 of available DF, it was proposed to allocate £67,000 to maintenance, £50,000 to reserve, and £229,000 to priorities within the two districts, some of which were identified by the AEG. Of the total, £229,000, £75,000 was to be made available for the hospital service and £154,000 for the community service. Out of the available DF of £421,000 this left a balance for disposal of £75,000 which would be used to finance area developments.

There was discussion at the meeting about the appropriate division of DF between the two districts. Since one of the districts (district 'A') was considered to be more affluent in terms of resources and facilities (an imbalance - if it was, indeed, an imbalance - with historical origins), the general feeling in the Group was that the 'underprivileged' district ought to receive a greater injection of funds in order to improve its standard of services. In this way, the AEG would be fulfilling its function of equalising inequities in the area and of
achieving an overall balance of service provision between the two districts. Only the CAMO queried the alleged existence of a lower standard of services in district 'B', claiming that the provision of services was fairly uniform throughout the area. However, in the end, the 'underprivileged' district did receive a higher proportionate share of DF. Of the £229,000 or so available for district developments, district 'B' was to receive £100,000 and district 'A' was to receive £130,000.

The summary of priorities, prepared by the Treasurer on the basis of discussion in the AEG at its first meeting and of his knowledge of area priorities for the health services it provided, was intended as a guide for further deliberation. Of the total sum being split between the two districts (ie £229,000), district 'A's' priorities (as provisionally determined by the AEG on the Treasurer's list totalled just over £140,000; district 'B's' priorities totalled £36,300; and the area's priorities totalled nearly £53,000. In district 'A', the bulk of funds allocated would, if the AEG had its way, be spent on priorities in the community service - health visitors and midwives. The bulk of funds going to district 'B' would be spent on hospital developments in the field of mental health (a national priority area). A primary factor in this decision was the location in the district of a 420 bed mental deficiency hospital. Most of the area priorities also lay in the hospital service. The Treasurer emphasised that the list of priorities in his paper did not
necessarily reflect those of the districts, although the items he had included were drawn from the original lists submitted by the districts.

In considering district priorities, the AEG had to contend with a further problem: the same priorities did not feature on both districts' development lists. For example, a request for health visitors appeared on district 'A's' lists but not on district 'B's'. The problem was what the AEG should do in this situation. It could either insist upon both districts implementing developments that it thought were essential, or it could permit the districts to implement different developments.

Finally, a policy for the two districts was agreed upon by the AEG. The DF available for the districts (£229,000) would be split between them (the 'under-privileged' district receiving a proportionately greater share), and the AEG would say to the districts: 'here are submissions that the area feels are important. Take them into account when setting your priorities'. If the districts could give good reasons for not agreeing to area priorities (although what constituted 'good reasons' was left un-stated) that would be acceptable. If not, the AEG would direct the district(s) to implement particular developments.

This still left some difficulties to be resolved in the relationship between the area and the districts over the allocation of DF. For instance, it was essential that the districts be informed of intended area developments since these could have implications for services run by the
districts. DEGs must, therefore, be given an opportunity to comment upon area proposals. For example, if the area proposed a new consultant post then this would most certainly have implications for the district in which the consultant would be located, since it would be responsible for providing supporting staff. Developments of this type are generally not favoured by districts because they involve pre-emptions of their DF by the area for priorities with which they have not been directly involved.

Once the AEG had completed its preliminary selection of priorities (and some alterations were made to the list prepared by the Treasurer), it was ready to proceed to the next stage of the allocation process. The districts were to be given a 'clean slate' and asked to list their priorities from scratch, keeping in mind the funds available to them, and the views of the AEG on desirable priority developments. After the districts had revised their lists and arrived at a final set of priorities, the AEG would consider these before submitting them to the advisory committees for comment. If approved, the health board, or rather one of its standing committees, the Policy and Resources Committee, would examine the proposed allocations. In the meantime, however, a paper would be submitted to the PRC giving details of the DF available. Of all the advisory committees, the AMC gave the AEG cause for concern. Officers had no idea how this committee would react to the recommended allocations. The AMC, it was felt, could pose problems and upset the planned timetable
which was designed to enable developments to be implemented as quickly as possible. It was thought that the AMC might suggest changes in direction different from the ones proposed. The other advisory committees were not expected to present any problems. Indeed, it was doubted whether the nursing or paramedical committees were sufficiently well organised to tackle the task.\(^6\)

11.3 The Districts' Dilemma

In the middle of March, the Secretary (Alpha) sent memos to the two DAs. These gave details of the board's revenue allocation for Year 1 and the DF that were available after actioning the expenditure already committed in respect of the running costs of capital schemes and non-capital developments brought forward from the previous year, the running costs of capital schemes for Year 1, a special development (extension to maternity hospital), and additional administrative costs arising out of reorganisation. District 'A's allocation of £130,000 was to be split thus: Hospital £68,000, and Community and School Health £62,000. District 'B', the smaller of the two, was allocated £100,000, to be split as follows: Hospital £52,000, and Community and School Health £48,000.

In drawing up spending plans, each district was requested to take note of certain policies which the area favoured for development. In the case of district 'B', seven items were listed which the area wanted the district to undertake. The memo stated that the AEG would 'give particular consideration to the implementation of the stated policies in
their consideration of the submissions'. Also listed in the memo were the priorities which came within the area's responsibility. The districts were notified of these so that duplication would be avoided. Both districts were requested to submit their proposals to the AEG by the end of March.

District 'A' had one meeting to decide upon its final list of allocations, whereas district 'B' took two meetings to complete its business. For both districts, the task of setting priorities was an important one; it was also an almost impossible one. The DEGs had to prune quite drastically their original lists of submissions and since requests in both districts were far in excess of funds available, the exercise was a messy one. Indicative of the near-impossibility of arriving at a set of 'correct' priorities was a comment from one DA: 'We'll (ie the DEG) be drawing them (ie items on which to spend DF) out of a hat'.

The discussions in district 'B' were more protracted than those in district 'A'. It is worth describing in some detail how the DEG in district 'B' proceeded since this provides valuable insights into the allocation process. First, members of the DEG were agreed that the developments the AEG had selected for the district to rate as high priorities would have to be included in their final submissions or else the AEG could overrule the DEG. The lists for community developments were examined at the first meeting. The AEG had four priorities in this sector, two
of which involved the hospital service too. One of these, an extension of occupational health services, aroused differing views among district officers. The DFO felt that there were more urgent things on which to spend scarce funds. But the DNO disagreed on the grounds that occupational health services would boost staff morale. The DA attempted to mediate by pointing out that since it would be October before appointments were made one possible way of saving money now would be to mortgage next year's funds in order to fund occupational health services: £4,500 could be allocated in the current year, and the balance (£2,500) the following year, in which a commitment to the full amount (£7,000) would be given. The £4,500 would comprise £2,000 from the community budget and £2,500 from the hospital budget.

There was agreement with the remainder of the developments listed by the area to which the district was requested to give priority. The rest of the meeting was devoted to listing the district's priorities. Only submissions listed as As were considered; the Bs and Cs were set aside. This process of elimination did not make the selection of a final list much easier because, in the case of community developments, there were only 3 Bs and 3 Cs, but 22 As. The As totalled £114,000 against the £48,000 available for community services.

The DEG proceeded to work through the lists (ie those that had originally been prepared and submitted to the area) item by item, spending at most about ten to fifteen minutes
on each item, but usually far less. It was very much a bargaining and a negotiating situation, with members of the DEG competing with one another in order to get what they could for their own services, while, at the same time, striving to reach consensus on the various allocations of DF. Thus, members were performing a dual role: (1) as individual officers representing particular interests; and (2) as members of a team trying to decide what was best for the district as a whole. It was not always easy to reconcile the two.

It is not possible to give precise details of all discussions on all items, but a few examples will suffice to convey an impression of the way in which the DEG conducted its business.

1 Nursing auxiliaries. There was a request for six part-time nursing auxiliaries to enable care to be given to the elderly within their homes. The DNO said this development was important because nurses were under great strain. The DA was in favour of appointing three part-time nursing auxiliaries, believing that these would at least make for an improvement in the service and would be better than nothing. But the DNO held out for six, although this was later reduced to five in order to arrive at the total allocation of £48,000; at this stage in the proceedings, the DNO was not prepared to consider anything less than the number of auxiliaries requested. Her argument was that nursing used to be a case of 'lulls and bursts' but that there were no lulls now. At this point in the meeting the DA was becoming concerned. The Group had only examined five items, most of which had been approved, out of about twenty. At this rate, the £48,000 would soon be gone. He wondered if the nursing auxiliaries had a high priority over other requests (including other nursing ones) and reminded the DNO that GP attachments were still to come. In the DA's view, the DEG seemed to be getting nowhere. Items had to be rated in order of priority. The DFO intervened to point out that by insisting on six part-
time auxiliaries at this stage, the DNO was 'wanting her cake and eating it'. The DNO retorted that she was simply aware of the stresses and strains on nurses, a point she repeated several times during the meeting.

2 Health visitors. This was also an area priority for the district. The DNO emphasised that the number of health visitors requested, 7½, were necessary. But the DA's view was that one had to be realistic and recognise that this number were not available. If there was no hope of appointing 7½ health visitors, then there was no point in allocating monies for that number. He suggested that the DEG put in for 2 and raise this number later if staff were available.

3 Enrolled nurses. These were required for GP attachment to improve the quality of service given. The DNO wanted 5 to be recruited and, once again, the DA thought this was unrealistic. Nursing was receiving a huge boost with 5 enrolled nurses and 6 part-time nursing auxiliaries. Which were more important? The DNO was of the opinion that enrolled nurses were more valuable. It was pointed out that the district could not allow so much money, from limited resources, to be injected into the nursing establishment. Trimming was necessary in the competition for scarce resources. According to the DA, the trimming that had taken place up to that point had been for reasons which had nothing to do with the necessity or otherwise of particular developments. For example, dental services had been trimmed because of confusion over what the CADO (who attended the DEG meeting in place of the DDO) wanted (see 6 below). The requests for health visitors had been trimmed because the number wanted was unrealistic, given the staff likely to be available. However, if 7½ health visitors had been available, then 7½ would have been recruited. In short, the developments that had been trimmed had been done so for reasons that had much to do with factors other than the exercise of free choice. The DNO was under constant pressure from her colleagues to trim. She responded by repeating her remark about nurses being under strain. By implication, she was refusing to consider strains elsewhere in the service. Finally, in this particular instance, with the DA repeating his dictum that something was better than nothing and was an improvement in the level of service, the DNO settled for 3 enrolled nurses as opposed to 5.
4 Clerical assistance for nursing officers. Over this request for 2 part-time shorthand typists, the DA said a job description was necessary as well as more information. The district had not quantified how the work was to be done; what exactly were extra staff needed for? The district, according to the DA, 'haven't done enough homework on it yet'. The DNO was forceful on the issue, claiming that she had assessed the need by going round asking nursing officers what their needs were and identifying things that were not being done. Her recommendation that clerical assistance was necessary in the form of 2 shorthand typists (part-time) was based on what the average nursing officer needed. But the rest of the DEG was not convinced of the need. No action was taken.

5 Physiotherapists. Again, the problem of staff availability facilitated trimming. An original request for 2 physiotherapists was reduced to 1. The DA was pleased - in his opinion a 50% improvement on a bid was not bad.

6 Dental services. There was some confusion over developments for dentistry which the CADO was unable to resolve. There were requests for 2 dental officers, 2 dental surgery assistants (DSAs), and 1 hygienist. It was thought within the DEG that the procedure was that dental officers were funded by the area, and DSAs were funded by the district, although there was uncertainty as to whether this was, in fact, so. The CADO was to check on this. In the event, the DEG was unable to earmark sums for either DSAs or a hygienist because DSAs were of no use unless dental officers were appointed, which was an area matter. It was decided, therefore, to allocate dental services an amount which was intended to be for either a hygienist or a DSA (should a dental officer be appointed). The DEG's preference was for the appointment of a dental officer and supporting staff.

After the lists of community developments had been worked through, at the end of this first round the total allocation stood at £56,550 (including area priorities for the district), that is, £8,550 over the monies available (ie £48,000). At this stage, of the 22 A-rated developments, 13 had been approved, 6 had not been approved, and
3 were to be funded from area monies. The DEG had to decide how to proceed. Since many appointments would not be made until late in the year, the £48,000 was considered to be more than adequate, in which case it might be possible to mortgage £8,000 of the following year's DF. A possibility would be to submit requests totalling £56,550 but to spend only £48,000. This would obviate the need for further trimming. At most, the district would only spend \( \frac{3}{5} \) of the sum in Year 1, with the rest going on non-recurring expenditure (eg furniture, equipment) in order to spend it before the close of the financial year. Furthermore, through the adoption of this strategy, more submissions could be included. However, there were risks in anticipating what might happen in Year 2 which considerably lessened the appeal of mortgaging DF for that year. No one knew what the future held; there might be no development money. There was a further snag, namely, that the board (or rather the AEG) was likely to follow the old RHB procedure for releasing funds and keep them back until staff vacancies had been filled by the districts. The districts would not receive a block sum of money but would only be able to draw funds as and when necessary. Therefore, the district was not in a position to mortgage Year 2's DF even if it had wished to do so. At this point, the DNO became concerned about district 'A's' allocation and wondered if they would have to fund the same priorities. She wanted to know if they would receive more money if, say, they could find more health visitors. The DFO reassured her by explaining that, to his knowledge,
district 'B' was coming off better than district 'A' in the allocation of funds.

It seemed, then, that the DEG had no alternative but to prune the list of community developments to £48,000, and it proceeded to do this in the manner illustrated by several of the examples cited above. DEG members searched for ways of avoiding having to make savage cuts and the DA, in particular, sought ways in which the district's interests might be furthered. One possibility (albeit remote) was to leave requests on the development list but to submit them with lower prices attached. The DA was convinced that the district could carry out such a manoeuvre without the area finding out. However, the DFO was not keen on the idea, despite the DA's assertion that the district 'could comb £2,000 from the lists in this way'. The DFO's objections centred on the confusion that would result for his staff; moreover, he wanted to be as accurate as possible in his costings in order to balance the books.

What prompted the DA to suggest the proposal in the first place was the knowledge that the area would control the allocation of DF and not the districts. The DA knew that because the district would be unable to spend £48,000 within the year, the area would transfer the remainder to non-recurring expenditure thus preventing the district from using revenue funds for other revenue purposes which it could plan for in advance of the area.

Finally, the DEG arrived at its allotted allocation of £48,000 after jettisoning one development that had been
approved earlier during the meeting, and after considerable trimming of other developments, mainly on the nursing side since there was more scope for reductions under this expenditure head than under others, both because large numbers of nurses had been requested (unlike other staff categories), which meant that they could afford to lose a few (or, rather, it was easier to make paper reductions in staffing, whatever the service needs may have been), and because it was usually impossible to fill all vacancies in nursing. At the end of the day, of the 22 A-rated requests, 7 developments were not approved, while 12 had been (of which 5 had been altered to arrive at the correct total) plus the 3 area-financed developments. The DEG seemed reasonably content with its work which had taken around 3 hours to complete.

A second meeting of district 'B's' DEG was arranged to discuss hospital developments. Speed was of the essence, and it took place the next day. The DA was unhappy about the lack of time available to reconsider the lists, and objected to the AEG's tight timetabling of the operation.

Area priorities for the hospital service in district 'B' were discussed first, one of which led to lengthy discussion arising from the cost implications. In its original lists, the district had submitted a request for a Clothing Manager and 9 Ward Housekeepers at an MD hospital. These developments involved expenditure in the region of £20,000 and the AEG had rated them top priority, in part because of the general staff shortages at the hospital (Ward House-
keepers would relieve nursing staff of non-recurring duties), but also because it was national policy to give priority to long-stay hospitals. However, with £52,000 to spend on hospital developments, the DEG was reluctant to spend almost half this amount on these two developments. If it went ahead with them, and with pre-emptions agreed by the DEG (see below), there would be no funds left. The DFO made it clear that 'if the full amount of money on the lists is allocated to these items, then we may as well call a halt to this meeting'. He pondered the possibility of improving the existing nursing situation as an alternative to appointing all these new staff. It was finally agreed that 3 Ward Housekeepers would be financed from DF while the remainder (ie 6), and the Clothing Manager, would remain on the lists and would be financed from underspending on the nursing budget as had been intended for some time (see below). The DA defended such tactics on the grounds that it was not going to be possible to gain access to the DF since these were to be held by the AEG until required for each specific development as it was implemented. Since the districts were unable to control their own allocations it would not be possible to switch funds from one activity to another, or from recurring to non-recurring expenditure. Funds could not be easily diverted since the AEG would be keeping a tight rein on the way in which DF were spent.

The saga of these particular developments (ie Clothing Manager and Ward Housekeepers) provides an example of the
friction which was present from time-to-time in the relationship between area and district. Not only was the DEG, especially the DA, frustrated at its inability to receive its share of DF and to switch these around as it considered apposite whenever circumstances demanded, but it had made little headway with its plan to finance these two developments from under-spendings in the nursing budget for the MD hospital in question. To do this, approval from the AEG was necessary, but none had been received. The DFO, somewhat disgruntled, commented, 'we never get formal approval, only approval in principle'. Nothing was in writing; it was a case of 'reshuffling the same pack of cards' with no new money available. The onus was always on the district to find more.

Apart from area priorities for the district, which totalled £7,300, there were other pre-emptions, necessitated by developments already agreed to by the former BoM, which were carry-forwards from the previous year. After some pruning, these pre-emptions stood at just over £28,000, which left £16,600 of the total DF available for developments in district 'B's' hospital service.

As at the first meeting, most of the time was taken up with deciding the district's priorities. Only the A-rated requests were examined, although there was a large number of them. From a total of 36 hospital developments, 7 were Bs, 7 were Cs, while 22 were As (one of the Bs later became an A making 23 As). The As totalled £165,800 as against the £16,600 that remained of the original £52,000. Once again,
savage pruning was unavoidable; as the DMO commented 'this is where the fun starts'. Some examples follow of allocation decisions taken at the meeting in order to illustrate the process.

1 Radiographers. According to the DMO, 2 radiographers were 'desperately needed'. The sum required for these appointments was over £5,000 and there was no problem about availability. While the DMO accepted that the auxiliary head at the hospital where the vacancies were underspent, this had not necessarily occurred under the radiography head. He explained that the demand for radiographers was the result of a new consultant radiographer who had been appointed at the beginning of the year; before his arrival there had been no demand for additional staff; the consultant had created a demand for this service and now required support staff to cope with the expansion. The DPO thought that perhaps the consultant was not doing more work but rather that others were doing less, but this was not pursued. The DA pointed out that if a consultant was appointed, it was essential to consider any necessary support services that would be required. He maintained that the AEG (which was responsible for senior staff appointments) should consult the districts when consultant posts were filled in order that the DEGs could consider what support services would be required (districts being responsible for providing these services). This was a prime example of the tensions which can occur in a two-tier structure when closely related functions are split between the tiers. Districts were not anxious to fund support services for consultants since these were pre-emptions on their DF, although in the present case, the 2 radiographers were accepted as being necessary (the allocation was reduced to 1 at a later stage of the proceedings - see below). The DNO interjected to say that she could put forward similar arguments, to those of the DMO's, for more nurses. The DA replied that that was why 'we gave you all the nurses yesterday' (i.e. at the meeting which decided allocations to community developments).

2 Clerkess. An appointment was necessary to cover extra work involving a new type of form. The DA was not sure that a clerkess was more important than a radiographer or a cook. But a choice had to be made: did one X-ray more people, or fill
out more forms? The other members of the DEG agreed that it was difficult to determine needs, especially when crises occurred like a strike or whatever. Clerkesses always received more work on these occasions. The development was approved.

3 Nursing staff (maternity hospital). This development was a late addition. After the lists had been scrutinised, the DA asked if members of the DEG had other requests in the light of changed circumstances since the original lists had been prepared. The DNO raised the matter of additional nursing staff at the maternity hospital although she agreed that the need had not been well-defined and that there were conflicting reports as to the necessity of more nurses. A factor in favour of the development was that the hospital was underspent by £1700. Against this, the DFO pointed out that the national birth rate was declining. The DA, moreover, was anxious to ascertain what sort of case had been made out for the request. In his view, the increase in staff establishment wanted was too great and, therefore, suspect. Since the development was not ready for funding on the basis of information available, the DEG decided to leave the matter meantime. It had not 'gone through the sieve' (ie the DEG). The DA emphasised that before any request went on the development lists, it had to be well-argued and searching questions must be asked within the DEG. A case for a development had to withstand detailed questioning.

Despite the DA's comment, items did, on occasion, appear on development lists without sufficient supporting data (as above).

Of the 22 A-rated developments, 8 were not approved (this rose to 9 after a further cut later in the meeting). One request was rejected on the grounds of insufficient information; another was on the list not to be considered along with other competing items but so as not to be lost sight of; and three requests for additional nursing staff 'to bring present establishment up to satisfactory level' were rejected because the establishment figure was unrealistic - there were neither the people nor the funds to fulfil it.
Nurses, it was agreed, would be employed when they became available; in the meantime, nursing money was going to ward housekeepers (see above). Of the 13 remaining A-rated developments, 4 were altered, ie a request for 9 ward housekeepers was reduced to 3 (the rest, as mentioned earlier, were to be funded from under-spending on the nursing budget at the hospital in question); a request for a clothing manager was also to be financed from underspending on the nursing budget rather than from DF (see above); a request for 2 domestic assistants at one hospital was reduced by half, and a request for 15 domestic assistants, 4 of which were A-rated, at another hospital was also reduced by half (ie from 4 to 2) on the principle that this was 'better than nothing'. Despite these cuts and trimmings, developments approved amounted to £20,950 (ie £4,350 above the monies available). After working through the developments on the list, the DA asked if there were any other developments which should be included on the final list. The DMO supported the appointment of a dietitian and this was added to the list despite the fact that the DEG was awaiting a paper from the DMO making out a case for such a person. In addition to this request, the DMO wanted a B-rated priority upgraded to an A. The development concerned a medical equipment attendant and the DMO felt that maintenance deserved a higher priority than it had hitherto received. Equipment was frequently approved without a thought being given to its maintenance. The DA agreed that this was a problem and gave the request A priority adding that it would not find a place in the queue
since it would add another £3000 to the total bringing it to £26,700 (including the dietitian).

The overspending on the allocation of DF had to be eliminated by combing through the final list of approved developments. 'Who's for the chop?' asked the DFO. The first development to be axed was the request for a maintenance attendant which had just been added to the list! Although it was appreciated that this development was an investment, since it could save the district (and the board) large sums of money on equipment loss and renewal, it was recognised that the request was not urgent in comparison with some others. A further saving was incurred by reducing the allocation of 2 radiographers to 1. The DFO wanted the occupational health service cut (this matter had been raised at the first meeting when community developments were being considered; see above), since in his opinion it was 'a millstone round our necks'. He suggested that the district introduce the service but that since it would not get off the ground until halfway through the year, the district could reduce the allocation by £2,500. A comprehensive service would begin in October and the rest of the allocation would follow in Year 2. The DFO thought he was being 'devious' in suggesting such a ploy, but the DA, who had had the original idea, maintained that he was 'a craftsman'. After further 'horse-trading' (the DA's term to describe the activity in which he and his colleagues were engaged), namely, the decision to fund a part-time, rather than a full-time, dietitian (£1500, a saving of
£1250), the DEG was looking for final savings in the region of £1,000. Officers were beginning to tire - the meeting, like the first, had lasted 3 hours. Said one: 'we'll be here all night. Let's get it finished'. In a state of near desperation, both to end the meeting and to reach the target, the list of pre-emptions was re-examined and a further £1,000 was combed from it by reducing the allocation for surgical instruments. The task, which had developed into little more than a bookkeeping exercise, was finally accomplished and there was general satisfaction that the target had been reached with such precision. Throughout the two meetings of the DEG to consider its allocations of DF, tensions were evident between the DA and the DFO, and between the DNO and the rest of the Group. The tensions between the DNO and her colleagues were typical of most negotiating/bargaining situations in executive groups at district and at area levels.

The DNO saw her task primarily as one of getting what she could for nursing and, even if not always successful, she was forceful in 'fighting her corner'. But the tensions between the DA and DFO revealed fundamental differences in the approaches of the two officers to decisions on DF, and to the relationship of the district with the area. For the DA, the overriding aim of the DEG was to 'get our hands on the money' in order to 'get it over here'. In his view, the present system slowed up decision-making because you had to wait for the ABG to approach the districts with non-recurring monies towards the end of the financial year,
anxious to see it spent. The DA advocated a procedure that would short-circuit this laborious, and not especially efficient, system and speed up the decision-making process so as to enable the districts to identify non-recurring money one month in advance of the health board. But the DFO had a different outlook and wanted to play the game by the rules. While not objecting to occasional manoeuvring, he refused to bend the rules to the point of deception. Consequently, he was not prepared to inform the health board that the district had staff at hand to appoint when this was not the case, or that 'extra' staff should be appointed, and then proceed to switch resources allocated for the purpose by the area to other preferred schemes. The DA believed that one had to be prepared to be flexible about such matters and not be frightened to take risks. In his defence, the DFO was certain that, in the end, the AEG would find out about the tactics employed by the district. The DA, in turn, suggested that the DFO was being 'ultra-cautious'. Although the DFO could have been overruled by his colleagues on the DEG, the differences of opinion between him and the DA over tactics was not pushed this far. Instead, the DA gave way on the grounds that if the DFO wanted to stick to the rules, then the DEG would have to accept that.

District 'A' spent considerably less time on its allocations; whereas district 'B' had spent a total of 6 hours, district 'A' had one meeting which lasted 1 ½ hours. However, the district had not allowed itself much time to con-
sider its developments - the DEG met less than 2 days before the deadline set by the AEG expired. District 'B's' DEG met one week in advance of the deadline.

District 'A's' DEG was incomplete for the meeting because the DNO was on leave. Items on the development lists concerned with nursing had been discussed with her at a preliminary meeting a week beforehand. As noted earlier, the district's priorities were not categorised in as much detail as district 'B's' (see Table 11.1). There were 11 A category priorities in the hospital service and 11 in the community sector. There were no B or C categories.

The DEG meeting was conducted very smoothly and agreement over allocations was reached with a minimum of delay. Although district 'B' had a higher proportionate share of DF, overall district 'A' received a larger allocation because it was a larger district, having 2,028 hospital beds, 4 health centres and 19 clinics, compared with district 'B's' 1,005 hospital beds, 2 health centres and 15 clinics. Notwithstanding these facts, district 'A' was, as has been noted, allegedly a better endowed district. Indeed, in the hospital sector, the DEG had difficulty in finding sufficient items on which to spend the DF available to it (ie £68,000), a situation which contrasted sharply with district 'B's' experience. Two factors contributed to this: (1) in district 'A' there were fewer pre-emptions (these, as noted above, consumed a large chunk of district 'B's' DF); and (2) district 'A's' complete list of hospital developments totalled £80,000 as opposed to district 'B's' hospital developments which totalled £258,000. At
one point during the meeting, the DA said, 'we're struggling to spend the money' (ie DF available for hospital developments), and when £62,000 out of the £68,000 had been allocated, he wondered if it might be possible to switch the remaining £6,000 from the hospital sector to the community sector. The AEG's approval would have to be sought for such a move although the DFO saw no objection since the split between the two sectors was arbitrary in any case.

At the close of the meeting, nearly £69,000 had been allocated for community developments, nearly £7,000 over the sum originally allocated by the AEG. But this was to be met from the £6,000 which the DEG planned to divert from the hospital service. There were few arguments over priorities at the meeting because few awkward decisions presented themselves. The district was able successfully to fund all its priorities and, moreover, allocate more funds to community services than had been envisaged. Nevertheless, the DEG was not entirely happy with the method adopted for allocating DF and the DFO thought it would be desirable if, in future years, more background information on proposed developments was obtained.

One problem district 'A' had, which it shared with district 'B', concerned the nursing establishment. The eventual aim of the DEG was to arrive at an agreed norm for staff ratios since, at present, there were several norms. The DA pointed out that 'the highest ratio was always favoured by the DNO'. One of the difficulties was that work study reports on this problem all reached
different conclusions.\(^8\) The Aberdeen formula was used a great deal and an improved, revised one was shortly to be produced but, as with all such formulae, the ideal was emphasised rather than what was acceptable. With all these considerations in mind, and in the absence of the DNO, the DFO wondered if he should set aside £10,000 for nursing. The DMO expressed the medical view on increasing the nursing establishment, which was that there was concern among consultants at the level of nursing care. The numbers of nurses were sufficient but their activity was not increasing. The DA was sceptical of the need for further nurses and wanted to be convinced of where the shortcoming was. The DEG decided that the disadvantage with setting funds aside was that it was not always possible to obtain staff - it was a recruitment problem rather than a financial one. Flexibility in such circumstances was vital, and, if no nurses were available, ward housekeepers could be obtained. However, in the present instance, the DA was not satisfied that the need had been fully assessed and he wanted to see how it was proposed to use the £10,000.

Nursing recruitment posed a problem for the district. Although it was in balance with its budget, if recruitment had been better then the district would have been overspent. Conversely, had recruitment been poorer, under-spending would have resulted. It was very much a hit-or-miss affair in which forward planning was hazardous. The DMO suggested that the best plan for the present would be to keep the £10,000 hidden from the DNO until the case for
more nurses had been established with greater certainty.

Both districts submitted their final lists to the AEG on time. In his accompanying memo, the DA in district 'B' pointed out that the posts being recommended in the fields of nursing, domestic staff and junior laboratory technicians were in relation to posts approved, and appointments made, by the former BoM prior to reorganisation, for which no funds had been provided. These posts accounted for a large proportion of the district's pre- emptions (around £13,000). The memo ended with a reminder that despite the proposed developments,

this still leaves extensive gaps in the health care services being provided in (this) district, and it would be greatly appreciated if any additional recurring funds could be made available, which would go some way towards the introduction of much needed improvements in the service.

In a shorter memo, the DA in district 'A' explained that the DEG felt that the developments requested for the community should receive rather more than the sum allotted by the AEG, and that a corresponding reduction in the sum allotted for hospital developments had been made by the DEG.

11.4 AEG: round two

The third meeting of the AEG, to consider the revised development lists, took place at the beginning of April. It gave chief officers an opportunity to examine what the two districts had decided within the priorities laid down by the AEG at its second meeting. The next stage was to decide how to present the lists to the various professional advisory committees who were required to comment
upon development proposals.

The fact that the AEG was 'feeling its way' in these allocation matters, through lack of precedent, was again apparent at this meeting. It had dominated discussion at earlier meetings, and reflected a more general problem, namely, that the AEG was unsure of its precise purpose. The view was expressed, as it had been on previous occasions, that the AEG ought not to scrutinise the developments proposed by the districts in too much depth. This was the Secretary's preference and although he commented on one or two of the items on the lists, he avoided detail and no changes were made to the lists. The Secretary queried district 'A's' decision to appoint two fire officers on the grounds that one would surely have sufficed initially so that the service could be phased in. He was also concerned that such a large slice of district 'A's' DF (almost £8,000 - about 13% of the total hospital development allocation for the district) had been ploughed into medical secretaries, and was puzzled by the allocation of part of this sum to a request for clerical support for medical secretaries who, apparently, were having to perform tasks that were not considered worthy of them. The Secretary was uncertain as to why this had received such a high priority and, moreover, why medical secretaries should require clerical support for tasks they ought to be undertaking. Similar questions arose with many of the proposed developments; exceptions were reasonably clear-cut, almost mandatory, proposals such as the need for fire officers in both districts. But over many of the items there was, in
the Secretary's words, an 'equal state of ignorance'. The Secretary pondered over what might happen if the health board discussed the lists and questions were asked by board members as to why a particular clerkess was so important. He for one would be unable to answer this kind of question. The CAMO suggested that the districts should attend the health board meeting at which developments would be discussed, but the Secretary was unsure about the desirability of such a move.

The CAMO did not favour a detached role for the AEG in scrutinising the lists and suggested two criteria by which the Group could (and, in his opinion, should) judge the revised lists: (1) the AEG must see to it that the districts did not get out-of-line, that is, they must be kept in balance; and (2) the AEG must see that development proposals were realistic. According to the CAMO, it was the task of the AEG to examine each item, although he accepted that chief officers were not well placed to do so, because of a lack of factual data. The AEG was, on the whole, inclined to the view that it should accept the districts' views on proposed developments since they were, after all, in a position to know. The general consensus was that everyone in the AEG was 'reasonably happy' with the lists as they stood.

Other matters were also discussed in connection with the districts' handling of their development proposals. The problem of the growth rate allowed for by each district as a precaution against unforeseeable commitments, was considered. Both districts had dealt with this in different
ways: district 'A' had allowed £8,000 for growth, whereas district 'B' had allowed £13,200. What members of the AEG wondered was whether they should expect both districts to allow for a growth rate out of their DF (ie a continuation of the system which had operated under the former BoM structure). It was decided to leave the system as it was with the proviso that at a later stage the AEG might consider increasing the allocations to the districts - there were funds held in reserve for this purpose. Although the discrepancy in the growth rate between the two districts disturbed chief officers, they accepted that there was no time for the matter to be resolved since it would involve referral back to the districts. Pressure of time prevented such a course of action.

There was also discussion to decide where a line should be drawn between the area financing staff appointments at senior level, and the districts having to finance supporting staff for senior appointments. This, as was noted earlier, was a problem which rather disfigured relations between area and districts. The matter arose in the light of district 'B's' confusion over its dental services (see above). The AEG decided that a dental officer and supporting staff were to be funded by the health board, rather than the dental officer by the area, and supporting staff by the district concerned. Splitting the provision of services between two tiers was recognised to be far from ideal. The procedure to be adopted would involve the area claiming back from the district the cost of providing supporting staff. However, there were still problems in deciding
upon an appropriate division of responsibilities between area and district in this matter because area appointments had all kinds of ramifications at lower levels. Although it was preferable, as a rule, if the area could finance supporting staff for senior appointments, it was not easy to know where to stop. For example, with new consultants, the area might be expected to appoint new house officers, registrars, nurses, and perhaps other staff as well. Moreover, there was an added complication, namely, that the more that was added on to any appointment (in the way of supporting staff), the more difficult it was to confirm the appointment since it involved a 'fair whack of money'. Splitting costs carried the advantage of spreading the load and making it appear that developments were less expensive than they in fact were.

Finally, the AEG discussed the involvement of advisory committees. The Secretary was concerned about what they would make of the lists. Would they, for example, look for, and expect to find, a story attached to each item? Stories for proposals had accompanied the original lists, particularly those for district 'A', therefore it was agreed that the advisory committees should receive them.

There were not many developments on the districts' lists which would be of specific interest to the AMC; most of the proposals would be of interest to the remaining advisory committees. The area's list of developments would be of interest to the AMC, since it dealt predominantly with medical developments, senior medical staff appointments being the area's concern. It was eventually decided
that each advisory committee would receive two lists. An 'A' list would include items to be put in order of priority by the advisory committees, and a 'B' list would include background information on items on the 'A' list to assist the committees with their priority-setting. The Secretary continued to worry about what the advisory committees might do with the lists. It was quite possible that they would find them unacceptable and tear them apart. If that happened, then the whole allocation process would have to begin again. The AMC concerned the Secretary most of all since it was the best organised advisory committee; the others would probably not know how to handle the lists. There was a further possibility that since advisory committees were preoccupied with getting themselves established, the allocation proposals might slip past without a great deal of attention being focused on them. Alternatively, the lists might have the effect of 'concentrating the mind wonderfully'.

At its third meeting, the members of the AEG were very conscious of pressure of time. There were still several stages to go through before the DF were actually disbursed. Once the advisory committees had examined the lists they would be returned to the AEG at the end of April. Time was important because it was acknowledged that, once the allocations were approved, six months usually elapsed before new staff were in post. Thus it would be January before the posts on the development lists would be filled. In the meantime, summer was approaching and this was not a good time for advertising vacancies.
11.5 Professional Advisory Committees
Towards the middle of April, 5 area advisory committees were asked by the AEG to express their opinions on the development proposals. The committees were: the Area Medical Advisory Committee, the Area Nursing and Midwifery Committee, the Area Dental Advisory Committee, the Area Pharmaceutical Committee, and the Area Paramedical Advisory Committee. They were requested to return their statements of opinion to the Secretary of the board towards the end of April, which allowed them two weeks to review the lists.

In the case of the Area Medical Committee, 11 proposals were submitted to it for review. These included proposals for 2 registrars, 1 senior house officer, 1 health education officer, and proposals for the development of services including a family planning service, and improved laboratory services. Supporting data, where available, were attached. Details of supporting services were also included; for example, clerical support for medical secretaries, additional medical secretaries, ward housekeepers, and so on. This procedure, ie submitting proposed developments, plus supporting data, plus supporting services was followed with the other advisory committees. Whereas the medical, nursing, paramedical and dental committees had reasonable numbers of proposals to review, the pharmaceutical committee only had two proposals to comment upon.

It was not possible to observe at first-hand four of the committees at work on the development lists, however,
access was gained to the paramedical committee and the following paragraphs describe how this committee performed its task.\(^{9}\)

The paramedical advisory committee spent \(1\frac{1}{2}\) hours one afternoon reviewing the proposals. Nine members were present, representing the principal paramedical professions, including chiropody, physiotherapy, occupational therapy, dietetics, speech therapy, and radiography (this specialty's representative was chairman of the committee).

Those present at the meeting expressed surprise at the way in which the proposals from the AEG had come 'out of the blue'. There was indignation and puzzlement that no one had approached the committee, or any members of it (apart from the chiropodist who had been approached by the DA or DMO for his development requests), to discover their suggestions for improving services. This was the first occasion on which those attending the meeting had heard about these allocations. Members wanted to know where the information in support of the proposals had originated, ie who had suggested these particular developments and when?

In the committee's view, immediate necessities had been taken up by the districts on an arbitrary basis. General dissatisfaction was expressed at the lack of any direct consultation of the committee by the districts.

To show its disapproval of the way in which the allocations of DF had been handled, each specialty represented at the meeting submitted, on the spot, a list of requirements based on assessments of establishment figures. These were
forwarded to the Secretary along with an accompanying letter from the committee Secretary. The committee hoped that in future years there would be an improvement in the haphazard collection of information, with each profession being asked to submit proposals which would then filter through the advisory committee. In this way, everyone would know what his/her colleagues were doing and the committee would be concerned with DF from the start. At present, there was no overall strategy, and allocations were dealt with by informal, ad hoc, unsystematic methods, like telephone calls to odd individuals who might lack the necessary knowledge. The committee saw its role in the allocation of DF as being one of commenting on what it identified as essential requirements. Since the committee was composed of people who ought to have been contacted originally, it was claimed that the district officers should have contacted the committee on the allocation of DF - this had not happened. The chiropodist said that things only happened if you shouted loudly. But one also had to know where to shout and at whom to shout.

Although some development proposals sent to the committee were supported with arguments, this was not the case with all of them and the committee felt it was wrong to be asked to comment on proposals which were not fully supported since it could not discuss them intelligently. One member suggested that 'maybe the AEG feels it is none of our business'. In general, the committee agreed that a much better way of conducting the whole process of allo-
eating funds would have been for it to have been asked for recommendations for additional staffing, which was the procedure followed for long-term equipment needs.

Apart from wanting to know where the information in support of particular proposals had come from, members also wanted to know whether additional staff requests applied to the hospital service or to the community service since the two sectors had been integrated in the development lists (integration, of course, being the main aim of reorganisation). There was some concern at the alleged bias in the lists in favour of the community, although a speech therapist commented that this made a 'nice change', and that such a bias, if present, was to be welcomed if the community needed, or deserved, extra resources. What the committee wanted to establish, however, were the grounds on which it had been decided that the community did deserve them. The speech therapist maintained that since the NHS was now an integrated service there was nothing to suggest that bias was in one direction rather than the other. But the chairman (hospital based) argued that a close look at the proposals revealed a strong emphasis on the community, with developments in midwifery, GP attachments, and domiciliary night nursing. It was her firmly held belief that none of these developments should be implemented at the expense of the hospital service.

Despite grievances about the proposals, the committee agreed that it was probably too late to change the lists. Therefore, it was decided to send a protest letter to the
Secretary of the board requesting better consultation in future. Furthermore, the committee did appreciate the difficulties facing the AEG in allocating DF. Available funds might not be used for the really vital developments since it was recognised that the area had to spend the money which meant, on occasion, using it for available staff rather than on staff who might be urgently required but who were not available. A current shortage of physiotherapists, for example, was due to an inability to fill vacancies, rather than because of lack of resources. Money had to be spent on what could be obtained rather than always on what was essential.

It was also believed by many on the committee that some of the problems affecting paramedicals were a direct consequence of their weak bargaining position on executive groups at district and area levels. The chiropodist maintained that paramedicals were at a disadvantage vis-à-vis doctors and nurses because they did not have officers to represent their interests either on the AEG or on the two DEGs. Even dentists had a CADO and DDOs who could be quizzed on various matters and put forward the dentists' views. CMSs dealt with the interests of the paramedical professions but came under the CAMO's authority.

At the end of April, all the advisory committees had submitted their comments to the AEG. The nursing committee had 'no criticisms of the proposals' to report. Although the proposals had arrived too late for discussion at the committee's April meeting, the chairman had made the informa-
tion available to members of the committee. The pharmaceutical committee was in agreement with the two proposals it had to consider. Likewise, the dental committee gave the proposals submitted to it 'complete approval'. No official written reply was received from the medical committee, but the AEG, through the CAMO, who maintained close relations with the committee, was informed that it had no objections to the proposals. The paramedical committee, as mentioned above, replied at length, enclosing assessments of establishment figures in some paramedical specialties like speech therapy, chiropody, dietetics, and occupational therapy. Although the committee 'unanimously agreed to endorse the proposals put forward by the AEG', the letter pointed out that

in view of the fact that, with the exception of the chiropodists and the two area posts, none of the professions concerned were aware that submissions had been put forward for additional staff, the committee would be pleased to know where the supporting data put forward on behalf of these proposals emanated from. There appears to have been no attempt, at district level, to approach the paramedical professions concerned and formally request their own comments on establishment figures. If this was the case the paramedical committee wish to voice their disapproval at the way in which information is being collated.

The Secretary of the board replied to this letter a month or so later and, in response to the points raised by the committee, wrote that

in a number of cases the requests for additional staff have their origins in submissions we inherited from the former BoMs. In other cases the DEG could see the need for additional paramedical staff. One difficulty is, of course, that the paramedical professions have, as yet, no one person at district or area level to re-
present their interests. The position will, of course, change when we appoint such officers as Area Chiropodist. Nonetheless, it would be unrealistic to expect all the paramedical professions to have district or area officers and one of our main reasons for submitting the proposed allocation of DF to your committee is precisely to enable you to put forward your own submissions. This may not be a completely tidy arrangement but I would say that the chances of the needs of the paramedical professions being overlooked are very slight.

On the point about establishment figures, the Secretary said that the figures were 'very helpful', but added that there was 'nothing to be gained by adopting higher establishment figures when we cannot recruit up to the existing ones'.

11.6 Policy and Resources Committee

The final stage of the allocation process for DF was approaching, when it would be the health board's turn to have its say on the proposed developments. Up to this point, only officers and advisory committees had been involved with the allocations, and mainly the former. The board, through its main standing committee, the Policy and Resources Committee (PRC), had been kept informed all along of the progress being made. The proposals were presented to the PRC towards the end of May. They were not, according to the Secretary, being submitted to the full board for approval.

The report sent to members of the PRC prior to the meeting set out details of the DF to be allocated, and the views of the five advisory committees, and it listed under six heads the final proposals that had been determined: medical, dental, nursing and midwifery, pharmaceutical,
paramedical, and supporting services (including clerical staff, laboratory technicians, ward housekeepers, domestic assistants). The allocations under these heads did not distinguish between hospital and community developments. In the words of the report, 'the beginnings of integration .... are apparent'. Nevertheless, the total allocations between the two sectors were distinguished.

The PRC's task was 'to consider and if appropriate approve the proposed distribution of recurring funds'. The meeting was of potential importance since this was to be the only opportunity afforded board members to state their views on the allocations of DF and, if they so wished, to suggest changes.

Consideration of proposals for allocating DF comprised one item on a full agenda. Of the 10 items on the agenda, the allocations came second last. Present at the meeting, which lasted 2 1/2 hours, were 12 members of the PRC and the 4 members of the AEG. Although the item on developments was the only one of direct interest to the researcher, the opportunity to observe the PRC working through other items provided an opportunity to get some perspective on how members approached, and dealt with, issues, what concerned them, who the vocal members were, and so on. All this peripheral activity served to provide a context to the specific interest in the PRC's handling of DF.

The overall atmosphere of the PRC was friendly and informal but businesslike. There was a certain amount of good-natured banter between members and officers, with the
former frequently poking fun at the latter. For example, some of the papers sent out to members for the meeting had not been clearly photocopied. One member suggested that this had been a deliberate move by the AEG to hide information from board members. On another occasion, the Chairman remarked on the clarity of a paper that had been prepared by the officers (he was referring of course to the content and not to the quality of reproduction), to which a doctor on the Committee replied, 'it's only the print that's clear'. Obviously, it is all too easy to read too much into these exchanges but they are illustrative of the uncertain relationship which existed between members and officers, a relationship that contained elements of suspicion and distrust, as well as an acceptance of the fact that the officers were at all times intent on getting their way at meetings. Furthermore, these humorous exchanges provided an outlet, a safety valve, for such feelings and thoughts, especially when most members avoided discussing their feelings about their role vis-à-vis that of officers in a serious fashion.

It was apparent that those members who contributed most to the discussion (and they tended to be local authority members) usually focused upon details, like the provision of car parking spaces at a particular hospital. They were keen to scrutinise the spending of minor sums of money and showed less interest in large sums. They were also anxious to get results (or, preferably, to see them) for money spent, and on not wasting it (which could be interpreted as including expenditure on items on which there was no
immediate visible return). Comments were frequently made to the effect that the service must be improved and that action on new capital projects must be embarked on speedily. Slippages in capital schemes were tolerated with extreme reluctance. There was some detailed questioning of officers on various matters, but at no time did this amount to a grilling, with officers beginning to feel uncomfortable. It was conducted with great politeness, with officers at all times remaining in control. Discussion of wider issues involving health care objectives or service provision for particular client groups was significant by its almost total absence. There were references to the elderly and concern was expressed at the shortage of facilities for them or at the unsatisfactory state of existing ones, but even so, the discussion was conducted in broad, vague and general terms. Overall, members seemed implicitly to trust the officers to a very great degree, and, in the circumstances as outlined in Chapter 7, it was perhaps hard to conceive of it being otherwise.

The Treasurer introduced his report on revenue allocations, pointing out that £389,000 for developments (the original £421,000 had been eroded by further pre-emptions on existing commitments) was a lot of money, and warning members that the development rate in future years would not be as great. The health service would be entering a 'bare period', consequently DF available the following year would be half what had been available in the present year. The total submissions for DF, explained the Treasurer, had been
made up from a variety of sources: former BoM requests, priorities suggested by the health board on previous occasions, and priorities which the AEG considered to be important. These had all been filtered on many occasions and had been approved by the advisory committees. Contingency funds of almost £25,000 had been set aside for a 'sweeping up' exercise later in the year. The element of the total DF to be spent on community and hospital services respectively had been stated by the SHHD, although the AEG had tried to ensure that a larger element of funds was directed to community services. The Treasurer explained that DF were used for alleviating pressure areas in staffing, and where services were not being provided to the extent one would have liked.

The Treasurer made a particularly interesting remark, after he had completed his review of recent events concerning DF, when he said that since the development lists had been prepared, the AEG was aware that the board might wish to give more emphasis to the domestic staff situation at a mental hospital in the area. The AEG, explained the Treasurer, would like to look again at this item since a higher priority for it was perhaps necessary. The Treasurer refrained from filling in the background to this move on the part of the AEG. In fact, his comments were made in the light of a recent visit to the mental hospital by a visiting team from the Scottish Hospital Advisory Service. Perhaps it was sheer coincidence that the Treasurer should have chosen this particular moment to emphasise this
particular development at this particular hospital. An alternative explanation is that the episode is illustrative of the impact that the SHAS can have on a board's priority-setting behaviour. Moreover, the Treasurer, in making this announcement, was anticipating, and thereby pre-empting, possible reactions from board members to the SHAS' visit.

Following the Treasurer's verbal report, there were very few comments from board members. One member wanted to know if workloads had been the criterion for deciding whether or not to develop a service and to expand areas of care. He was particularly concerned about pharmacy, where a service had begun with one person and now was a large department which had 'just grow'd and grow'd'. But this point was not taken up. Instead, discussion centred on the need for pharmacists and the importance of the ward pharmacy service. The central thrust of the question, namely, was the relief of workloads only to be achieved through advocating 'more of the same', remained unexamined. Another member raised the matter of equipment developments and wondered if these were included in the lists or whether they were a separate concern. The Treasurer explained that equipment came within the category of non-recurring funds and that requests for these funds would be considered separately. The episode demonstrated the ignorance of some members concerning the operation of the health service budgetary arrangements.

The recommendations for developments were approved with
very little discussion and no opposition. The allocations went through the PRC in about twenty minutes and the board proceeded to the final item on the agenda.

After the meeting, the Secretary expressed surprise at the lack of discussion. He thought that former BoM members especially would have commented on some of the submissions carried forward from the former BoMs. The Treasurer, however, seemed less surprised at the lack of discussion, and explained how in the former structure he used to prepare a paper each year with all the submissions for DF listed plus a list of developments which the officers considered deserved priority alongside. But he no longer did this because in his view it was a waste of time. Board members now just received a list of developments which the officers had decided upon, and were not, for instance, shown the lists prepared by the districts upon which the AEG based its final proposals (although if any members were to request such information it would probably be supplied). For the Treasurer, the absence of any discussion by members merely confirmed him in his view that the whole concept of health boards was unsatisfactory.

11.7 Aftermath
Although the case study is not concerned with policy implementation (in this instance the actual spending of DF by the area and districts according to the agreed development proposals), this is not to deny the importance of this stage which has received insufficient attention in administrative literature.(10) However, it is worth sketching
briefly the history of one event that occurred in district 'B' (Alpha), which upset completely the proposed allocation of DF which had received the board's approval. The significance of this event in the overall allocation process is considered in Chapter 13. Suffice at this point to say that the episode illustrates many of the uncertainties and constraints which were encountered in the decision process affecting DF.

The problem over nursing staff establishments in district 'B' was first noticed during the summer of Year 1, after the health board had approved development allocations for that year. It transpired that in 1974, prior to reorganisation in April of that year, the former BoM had agreed to increases in nursing staff establishments for its hospitals without funds being available to meet the cost. For various reasons, some historical (see below), staff had been recruited in error to fill these additional posts, with the result that in the general and maternity divisions the whole-time equivalents of 26.5 staff had been appointed in excess of available funds. This overspending represented approximately £60,000 annually. There was a similar financial deficiency in the mental deficiency and psychiatry division but it had arisen mainly as a result of acceptable staffing levels never having been fully funded. Therefore, the total financial deficiency amounted to a sum in excess of £100,000.

The situation had only come to light that summer (rather than sooner) because of the upheaval associated with re-
organization, and because of an absence of management information. The Treasurer explained in greater detail why it was not until the DF for Year 1 had been allocated that it was discovered that the nursing situation in district 'B' was getting out of hand. Over a six month period staffing levels rose sharply, but the trend was not detected earlier because the relevant statistics were not used then in the way that they were now. The emphasis used to be on financial returns which involved an inevitable time-lag before problems, if there were any, revealed themselves.

The AEG considered the possibility of meeting the costs of these additional staff from non-recurring funds until the end of the current financial year at which time, if the calculated establishment was less than that in post, some 'levelling-down' would take place. In the meantime, it was agreed that the district should be authorised to utilise its DF for Year 1 on a limited basis, that is, only community staff developments and those hospital staff developments regarded as priorities should be implemented immediately. Moreover, this should be done while appreciating that the situation which had been brought to light might warrant a recommendation to the board that it reconsider its earlier decision regarding developments pending the outcome of an assessment of nursing staff requirements in Alpha which was already under way. District 'A', meanwhile, was permitted to proceed with its developments.

The PRC, at a meeting in early October, agreed that the
cost of additional nursing staff in district 'B' should be met during Year 1 from non-recurring funds and not from DF. It agreed also to recommend that the other developments submitted by the district and approved, costing £48,560, be considered against DF that might be available in Year 2. This move resulted from a decision by the AEG, and approved by the board, to freeze district 'B' s allocation of DF for Year 1 because of the overspending. While 1/3 of the DF was spent by the district on priority developments, the rest was transferred to the nursing head. The area agreed to meet some of the costs incurred by the nursing crisis because a comparison of hospital staffing levels in the two districts showed district 'B' s to be lower. The outcome of all this activity was that district 'B' s developments, in the words of the DFO, 'never really got off the ground, apart from those in the community'.

The crisis over nursing staff establishments arose for two reasons which have been touched on briefly. First, with reorganisation in the offing, the former BoM took, according to the DA in district 'B',

a wee bit of licence. Before they went out of office, if someone was shouting hard and always wanting something and they knew they didn't have the responsibility for looking after it, they could quite easily say 'OK let's improve it now because by the time someone's appointed and it starts to bite it's not going to be in our day'.

It was the BoM's final act before reorganisation, although it had no funds to implement the new staffing levels it had approved. Second, the problems over the recruitment of nurses have historical origins. Traditionally, recruiting nursing staff has been an extremely complex task. Although
there are still problems, they were particularly evident before reorganisation. Former hospital authorities were unable to recruit easily because staff were simply not available, although funds were. This state of affairs conditioned thinking on the subject of nursing staff levels, which led directly to the sort of problem encountered in district 'B'. Since reorganisation, which occurred at about the same time as the growth in unemployment, nursing staff were more plentiful, and recruitment was less of a problem (there were still shortages in special areas and in some specialties). Recruitment occurred rapidly, with the attendant risks of overspending, because it was thought that as many nurses as were available should be recruited in case this state of affairs was short-lived. In short, attitudes, which were essentially of a short-term nature, towards nursing recruitment had not changed in line with actual recruitment patterns, and were a legacy from the past when staff had been scarce and when all those available had been rapidly snapped up. But in a situation where nurses were in adequate supply, boards were in a position to choose when to recruit and there was, or ought to have been, less need to fear shortages.

As mentioned above, district 'A' was able to proceed with its staffing developments as planned. However, one change was made to its allocation proposals in response to a visit by a team from the Scottish Hospital Advisory Service (SHAS) to a mental hospital in the district (see above). In early June, in anticipation of the SHAS' report (which was expected shortly) on this hospital, district 'A' requested
permission from the AEG to appoint additional domestic staff immediately. It was agreed that the district be asked to identify those proposals on its exiting lists of developments which, in its opinion, merited a lower priority than the proposed additional domestic staff. It is worth recalling that when the original lists were submitted in February, district 'A's' included requests for 8 domestics and 1 domestic supervisor for the mental hospital in question, although neither were A-rated. In the final revised lists, there was no mention of the two requests. However, in anticipation of the recommendations of the SHAS' report, these development proposals were quickly resurrected.

11.8 Beta: Development Funds (Year 1)

The account so far of the allocation of DF in Year 1 has been based on events in Alpha. Beta, as was explained at the start of the chapter, was not included in the field work until towards the close of Year 1. However, with the benefit of officers' hindsight and official minutes, it is possible to reconstruct in outline what happened in Beta in Year 1.

DF in Beta for Year 1 amounted to almost £348,000, while the requests considered were in excess of £900,000. Thus the scale of operation was very similar to that in Alpha, just as many of the problems over allocations were akin to those experienced in Alpha. For example, Beta had severe nurse staffing problems in one of its districts (district 'X'), where there were shortages in two large hospitals, one psychiatric and the other MD (district 'X' had 3,155
hospital beds, 2 health centres and 13 clinics compared with 846 hospital beds, 6 health centres and 7 clinics in district 'Y'). Requests for additional nurses for these hospitals came to £87,000, very nearly 1/3 of available DF. However, because of overspending on the nursing budget in the previous year, district 'X' received very little free DF, and most of what was obtained went on nursing. The AEG decided to 'punish' the district by withholding from it most of its share of DF. Another problem was area-wide shortages in community services. In particular, community nursing ratios were lower in Beta than in many other areas. Consequently, improvement of these was given high priority, although it was realised that there might be difficulties in finding trained recruits. The emphasis on nursing led district 'Y' to allocate most of its DF on nursing staff, both in the community and hospital services.

The procedure for allocating DF in Beta followed broadly the same lines as those described above for Alpha. The allocation process began towards the end of January when the AEG held a joint meeting with the two DEGs which the board chairman also attended. District officers were requested to submit their development proposals for Year 1 by the end of January, and to indicate their priorities in terms of three or four 'bands' ie A, B, or C (as in Alpha). The AEG then examined the priorities in the hospital and community fields separately, although it was recognised that this was not an ideal arrangement, and one which would not be perpetuated longer than was necessary. At the joint
AEG/DEG meeting, it was explained that the revenue allocation from the SHHD was calculated on a formula basis and without reference to the volume of requests to be considered by an individual board. The Secretary suggested that the board hold a reserve fund for contingencies (akin to Alpha), and gave as an example of the type of situation which might occur the possibility of an unexpected sharp increase in nurse recruitment. If no unforeseen circumstances arose, the reserve fund would be distributed to the districts, probably in October or November, for use on non-recurring items.

At a further joint AEG/DEG meeting in March, there was discussion on how development monies could best be allocated. It was agreed that sums of money should be made available to the districts in due course in respect of the priorities they had arrived at. These priorities were in addition to the requests which had been obtained from heads of departments, sector administrators, and others, and were part of an interim assessment of health care problems in the area which had been requested by the SHHD from all health boards. The aim of the exercise was to identify and quantify current and future health problems in the area, and, as a first priority, the fields of mental disorder and child health were to be examined, followed by other areas of health care. District 'X's' priorities included shortages of nurses (see above) and domestics and a shortage of beds, which would require additional nurses to staff them. District 'Y's' priorities included the development of preventive medicine (the DMO was committed to this), and an
improvement of the geriatric service. The assessments of need were expressed in rather general terms. It was further agreed at the joint meeting that an additional sum of DF should be allocated to each district which they would be free to use either to augment the first allocation, or to meet other demands such as those submitted earlier to the board as their development proposals.

The CANO explained the procedure adopted by the AEG for deciding allocations in Year 1. Some of them were decided upon as a result of former BoMs having committed the board to certain developments (cf Alpha's experience). To a large extent, therefore, DF were spent for Beta, an outcome contributed to by previous overspending. When the development lists reached the AEG from the two DEGs, they were scrutinised and some requests were discarded so that a reasonable list, in terms of available resources, could be compiled. As in Alpha, the districts' priorities fell largely into the A band. The CANO's practice in Year 1 had been to meet separately with the two DNOs and go through their lists with them, and ask for their evidence, and be convinced that these were the priorities. The CANO said that by the time the lists reached the AEG I at least had my own priority list in the sense of A is more important than B. We (ie the AEG) still tended to battle for our own bit of money at that stage - we still weren't thinking as an AEG. (Our view was that) we'll get this (particular development) onto the short-list and go on from there. We ended up with a fairly long short-list of all the things we saw as being the priority for our own discipline. It was only at the final meeting that you
began to set off your priority against a medical priority, or an administrative priority.

If minor differences in approach are set aside, Beta allocated its DF in Year 1 in remarkably similar ways to Alpha. The two districts compiled lists; the area scrutinised them and selected its priorities which the districts were expected to follow; the advisory committees approved the proposals; and the board finally approved them. Like Alpha, Beta subsequently experienced difficulties over recruitment in nursing which led to overspending on the nursing budget which, in turn, distorted the implementation of developments.
In this chapter, the allocation process is described in Year 2. In the next chapter an attempt is made to analyse the processes described in the last chapter and those to be described in this. A final chapter draws some conclusions from the case study.

12.1 Development Plateau

In his conclusions to the Financial Review for the year prior to the start of this study, the Treasurer of Alpha confirmed what will have become clear from the description in Chapter 11, that emphasis had been placed by the board on using its limited DF to bolster the service where this was most needed. But a note of caution was sounded, in that while Year 1 might still show a reasonable rate of growth (which it did), all indications suggested that subsequent years' development monies would not allow services to be developed at the same rate. As a result, it would be even more important for the board to look very closely at itself to see whether the resources which it had were being used to the best avail for the benefit of patients.

The Treasurer wrote: 'We all must be prepared to take, what in isolation may be unpleasant decisions, so that the Service as a whole may be as efficient as possible both in organisational and financial terms'.

The Treasurer's concern over the future availability, or rather non-availability, of DF was realised, though not
immediately. For most of Year 1, there was no indication that Year 2 would be markedly different. The Secretary in Alpha was even suggesting ways in which the allocation process for DF might be speeded up and started earlier. Although there were rumours in circulation which hinted that growth monies would be reduced, it was not until mid-July (Year 1), when the Secretary of the SHHD sent a letter to health boards outlining the forthcoming cuts in development monies, that administrators knew for certain what lay ahead. Their worst fears were confirmed when, in late February, health boards were notified of their revenue allocations for Year 2 in a letter from the Scottish Office. The announcement was immediately followed up by a circular issued by the SHHD, NHS Circular No 1976 (GEN) 16, on the use of resources in the NHS. It was followed a week or so later by a third letter, this time from the SHHD, on the cash limits which were to apply to revenue allocations. Together, these four official documents provided the context in which events in Year 2 concerning DF unfolded.

The first document, the letter from the Secretary of the SHHD, was issued to key personnel in health boards and it noted that between Year 1 and Year 2, the growth of current expenditure would be under 2% (in Year 1 it was around 3%). Therefore, in an effort to keep staffing under strict control, boards were asked to avoid entering into any commitments for Year 2, or future years, which would incur large expenditures.

In late February, boards received their revenue allocations
for Year 2. These included an element for development monies (which amounted to 1\%\%\%). To conform with the government's policy for controlling public expenditure through the introduction of cash limits, the allocation also included provision for the cost of pay awards which might become effective during the period and for price increases as well (the usual practice was for the SHHD to provide additional funds to cover pay awards and/or price increases as they arose). Boards were expected to ensure that expenditure on hospital and community services did not exceed the allocation.

At about the same time, health board Secretaries received a circular from the SHHD,\(^{(2)}\) which contained advice of a very general nature on keeping all 'existing use of resources under continuous review, in order to ensure that they are being used to the best advantage'. Furthermore, members of staff were requested to appreciate 'that improvements in some sectors of high priority in the service will only be possible if savings are made in others'.

Since salaries and wages account for around 75\% of the total cost of health services, the circular emphasised the need to bring staffing under strict control (this had also been the subject of an earlier circular in August, SHHD/DS (75) 144). It stated that, 'New posts should not be created nor vacancies filled in any discipline unless it is clear that the post is needed to enable a specific job of work to be done and that that job has the necessary degree of priority ...' \(^{(3)}\) Effective control over staffing was
necessary so that overspending on the board's financial allocation could be avoided. The circular singled out administrative and clerical staff for particular attention.

The latest staffing returns indicate that there has been a marked acceleration in the rate of growth of administrative and clerical staff, and the Secretary of State considers that in present circumstances firm action must be taken to stabilise, at their current level, the numbers of this group of staff. (4)

The fourth document referred to above dealt with cash limits. The letter informing boards of their revenue allocations for Year 2 had referred briefly to cash limits and this latest letter, issued in March, included more detail about the factors taken into account in determining the cash limits on allocations. The letter also reported that up until 1980 current expenditure on hospital and community services was programmed to increase at about 1.4% per annum (ie almost half of the growth rate in Year 1). The cost of all developments, including the costs of running new hospitals and other facilities, would have to be met within the sums available. Unlike previous years there would be no additional sums allocated for such purposes. The letter concluded with a plea to boards to place greater emphasis on achieving the most effective use of available resources and on obtaining savings by improvements in efficiency.

A perusal of a random sample of health board minutes during this period revealed a general picture of stasis. Almost everywhere, available monies would virtually all be taken up by inescapable commitments, particularly for running
costs arising from capital schemes which would be completed in Year 2. These pre-emption would leave very little money available to improve the service. Moreover, the general view was that it would be prudent to assume that this was not simply a temporary setback, but would continue beyond Year 2. While recognising the unlikelihood of there being much scope for improvements, health boards saw the reductions in growth monies as an opportunity to scrutinise priorities very carefully and to ensure that boards obtained the best use of available resources. Restrictions on DF, it was believed, created a unique opportunity for a comprehensive review of present services, since new developments would require to be funded entirely, or mainly, from the reallocation of existing resources. For most health boards, unless savings could be achieved in revenue expenditure in order to allow expansion of existing services, revenue monies for Year 2 would be insufficient. How far boards were able to put their intentions into practice is examined later with reference to Alpha and Beta.

Alpha's PRC was informed of these developments, and was told that from a likely growth rate of 1 1/2%, as compared to between 3% and 5% in previous years, just under 1% must be deducted for the running costs of major national capital developments in Scotland (District General Hospitals, etc). It was likely, therefore, that the remaining balance for general growth would amount to no more than 0.8%. In respect of Alpha, it was estimated that the amount involved could be £150,000. Against this sum, potential commitments (eg developments in district 'B' and the board held
over from Year 1, nursing staff in district 'B', and so on) amounted to £440,000. At this early stage (towards the end of January), the PRC was requested simply to note the position and to instruct officers to examine the implications of the whole position and report back. In fact, as time went by, it transpired that Alpha had even less room for manoeuvre than its officers thought (see below).

In Beta, a similar situation obtained. In March, the PRC was informed that a full analysis of the financial situation might reveal that a slightly higher level of developments than the 0.8% previously reported would be possible. However, it was pointed out that if junior doctors' salary increases were implemented, a preliminary estimate of the additional cost to the board being £65,000, this would represent a commitment in respect of developments which could not have been accurately forecast. The funds to finance the award would have to be found from within the board's allocation and would not be forthcoming from the SHHD. In a normal year, boards received sufficient DF to cover unexpected contingencies, but with DF in short supply, Beta, in common with other boards, had no spare capacity. If 0.8% of Beta's total revenue allocation was available for developments (see below), this would give a figure of around £173,000.

12.2 The Scope for Savings

For Alpha and Beta, a 'development plateau', for that is what the fall in the level of development monies amounted to, was an unprecedented occurrence. To cope with it, each board adopted a slightly different procedure, although
both encountered similar obstacles, and both found it extremely difficult to make a great deal of progress. Officers in both boards had planned to handle developments in Year 2 along similar lines to the approach adopted in Year 1. This was not now possible; a new situation demanded a new response.

In Alpha, the two DEGs, the advisory committees and others were approached by the AEG with a view to obtaining suggestions as to how they would see health care patterns being changed in order to ensure that those items which were of highest priority in the health care of the population were not held back because of lack of finance. The advisory committees were approached at an early stage because their cooperation was vital if savings and/or re-allocations were to be achieved. In addition to these initiatives, the AEG set up a Constraints in Expenditure Committee to coordinate the use of financial and other resources. This was a small committee which had no board members on it and was entirely made up of officers. It was established to identify small savings and draw up 'Good Housekeeping' programmes each of which would save the board a few hundred pounds over the year. The Secretary did not hold out any hope for big savings in the short-term; these would only come in the long-term although the possibilities were extremely vague. Moreover, they were controversial, since they involved closures, change of uses, and so on. Over such issues, one quickly came up against the entrenched problem of clinical autonomy.
Most of the data relating to events in Year 2 concerned with identifying savings were derived from minutes, reports and interviews. Significantly, it was not possible to observe meetings because, according to the Secretary of Alpha, 

there have been no specific discussions on this. It has been piecemeal, with ad hoc items on the AEG agenda. These bits and pieces have been pulled together into papers for the PRC. We've been nibbling at the problem. It's an example of an incremental approach to the subject - there has been no fundamental reappraisal. (Emphasis added).

This comment on the position at the time indicated a decided shift from the board's earlier stance when it was being proclaimed that the resource 'crisis' provided a valuable opportunity to undertake a searching review of existing commitments (see above). Although the intention to pursue a non-piecemeal approach to these matters may have been sincere, the reality was less dramatic than the rhetoric led one to expect.

Alpha's Constraints in Expenditure Committee performed a small, but valuable, role in the attempt to effect savings. It examined various suggestions and proposals put forward by the districts, advisory committees and others for ameliorating the financial position, and a preliminary list of recommendations was submitted to the PRC for consideration in mid-March. The economies considered fell into two categories: short-term, and medium and longer term. Suggestions in the short-term category, it was stated, would be effective within twelve months, and included items of a 'Good Housekeeping' variety, such as: (a) improving
the handling of mail by making more use of second class rate; (b) making the best use of transport services by ensuring that existing vehicles and staff were being used efficiently; (c) using paper economically; (d) eliminating unnecessary telephone calls during peak periods; (e) cutting attendance at courses for staff; (f) ensuring cost consciousness by cutting back on heating and lighting; (g) controlling prescription costs; and (h) controlling the overuse of laboratory and X-ray services. Altogether, there were 22 items on the short-term list. It was accepted that the various suggestions 'might not achieve immediate financial benefit but are aimed more at stimulating staff involvement in cost saving and cost effectiveness'. It was reckoned that if every member of staff could save £10 in a year the total saving would be over £50,000. Clearly, some of the economies would be easier to achieve than others. While the majority of them relied on staff cooperation in order to ensure success, (g) and (h), in particular, could be interpreted as unwanted administrative interference in the clinical sphere which might lead ultimately, to an erosion of clinical autonomy. Medium and longer term economies were expected to be effective beyond twelve months. Suggestions in this category (there were eight altogether) contained policy implications for the board. For example, in dental care, it was claimed that fluoridation of the water supply would, after an initial capital and revenue cost, reduce the level of dental care necessary because of the adoption of a preventive approach to dental health. Other savings in
this category could be achieved through the change of use, or closure, of underused units. For example, at one particular Home with 20 beds there was an occupancy rate as low as 25%, and the cost of running the Home in Year 1 was estimated at £30,000. The Committee's comment was that 'many of the cases arise as a result of social rather than health problems'. Its recommendation was to transfer the patients to other units and close the Home. Another suggestion for achieving an optimal use of resources was that a maximum utilisation of beds would contribute to greater efficiency, eg reduction of waiting lists, at little or no extra cost. According to the Committee, 'This comes down to ensuring the effective use of resources without any real increased expenditure but rather by re-location and a review of the system to increase efficiency'. There would be no direct financial saving but such a measure would obviate the need for increased expenditure.(6)

In Beta, an attempt was made to effect savings through joint AEG/DEG meetings. These were held in October, several months before the board knew precisely what its revenue allocation for Year 2 would be. The theme of the two meetings (one with each district) was 'an attack on inflation', and their purpose was to examine the economic situation as it affected developments in the NHS, and to find ways of making savings by reallocating resources. In an attempt to fulfil these objectives, officers went through the various heads of expenditure in order to determine, in broad terms, what scope there was for using existing resources better. The AEG was anxious to hear the
DEG's views on these matters.

One of these meetings, chaired by the Secretary, was attended. The Secretary began by mentioning a recommendation which had been received from the AMC over staffing. The AMC wanted every post falling vacant to be scrutinised carefully before being filled (the same view was the subject of a SHHD circular issued the following February: see above). The Secretary thought there were practical difficulties with the idea (see further below), but felt that since nearly 75% of expenditure went on staff perhaps the DEG (district 'Y') had some suggestions to make.

Prior to a discussion of possible economies, the Treasurer presented a brief résumé of the current financial situation as it affected the health board. He explained that in Year 2 there would be a modest increase from the SHHD of 0.8% which, at this point in time, would not be for new developments but to fund those already entered into in Year 1 (as noted above, Beta's AEG informed the PRC five months later that there would be a small sum of money for developments; see further below). The Treasurer expected the period of 'nil' growth to continue until about 1980 and concluded that the board, indeed, the NHS as a whole, had 'reached a plateau - we are neither going up nor down', and any essential developments would have to be funded from savings. As events turned out, these gloomy prognostications were not completely accurate.

Members of the DEG were concerned about the stalemate and spent ten to fifteen minutes clarifying the situation with
the Treasurer. In particular, they wanted to know about the likely impact of inflation and price increases and about the revenue consequences of capital schemes. The Secretary explained - 'another dismal nail in a black coffin' - that price increases would have to be met from existing resources. The DMO was especially concerned at the loss of DF, and maintained that the board had not even begun to equalise the differences in the local authority services (now under the wing of the NHS). Possibly the DMO's former position as an MoH accounted for his concern.

The point was made several times that to improve the service would mean less of something else, since there were not going to be additional monies. On the other hand, it was acknowledged that savings and/or the reallocation of resources were not easy options. On the contrary, they were riddled with difficulties, which this meeting clearly identified. Of course, these were not peculiar to Beta, being equally applicable to Alpha, especially in view of Alpha's commitment to a series of measures designed to effect savings thus enabling resources to be reallocated.

The DA at the joint AEG/DEG meeting in Beta raised a crucial point (one that would assume greater significance in the months to come), which was at the root of the difficulties both health boards encountered in trying to effect savings and/or to rationalise existing services. He was concerned that if a district managed to save money, would this be allocated elsewhere and disappear from the district's control. If this was the case, what incentive was there for the district to save resources? The Secret-
ary did not consider an incentive necessary since everyone was working in a national health service. The DA replied that this was all very well but that things did not happen like that, 'human nature being what it is'. This issue was to crop up frequently during Year 2. Clearly, there was no easy solution to the problem, other than for a district to remain secretive about any savings it managed to make. In fact, the Secretary said as much when he suggested that if savings were identified, the district could spend them without informing the area. The DA firmly believed that enthusiasm was vital if savings were to be made, otherwise, apathy would be the result. It was, as the CADO put it, a matter of business procedure versus human nature.

Throughout the meeting and, indeed, throughout the observed period of resource constraint in both health boards, the catch-phrase on everyone's lips was that resources 'must be used to the best advantage'. No one, however, was quite sure what this meant, and no definition was proffered. Most officers, like the Secretary in Beta, simply claimed that it was their job as managers to see that resources were used properly and that they were not doing their job if they neglected to do this. By implication, the problem was perceived as a technical one, to be solved by management processes and techniques. Values and political judgements, although present, remained at a subconscious level, rarely surfacing in discussions between officers, except to the extent that progress in any one direction was likely to be met with fierce opposition
from some quarter or other.

An attempt was made at the joint AEG/DEG meeting in Beta to identify the scope for savings. It was not a simple task. As one officer commented, in many instances one had first to spend money in order to save it. An example of this dilemma was the community health service, where an injection of funds might lead eventually to savings through a reduction of demand on the hospital service. There would, however, be no immediate gains from such a course of action.

Various proposals aimed at effecting savings were discussed. Only the main ones will be reviewed briefly here for illustrative purposes. There was a suggestion to close wards in the summer months to enable the health board to cut down on relief staff. Bed occupancy rates at certain hospitals were examined. In district 'Y', there were two hospitals which were high cost as a result of low bed occupancy. But each possible course of action put forward to resolve the problem raised other problems. For example, to step up bed usage would require additional staff; to change usage would incur opposition from clinicians; and ward closures over the summer months were not a cost-free option. Quite apart from likely opposition from the medical profession, and possibly other professional groups, transferring patients was troublesome for staff and patients alike. The possibility of ward sharing among consultants was considered but there were doubts expressed concerning its feasibility when the majority of consultants had fairly
fixed views about their wards and how they wanted them run. It was accepted by the officers that very few wards would be closed if resistance was too great, but that the attempt had to be made. As a first step, more information was needed on occupancy rates and the length of inpatient stay which the CAMO argued was too long in the area. The DMO was concerned that one could only show savings by cutting services. If that were so, then the obvious services to be cut would be those whose results were not easily quantifiable, like preventive services. In the field of primary care, it was agreed that not many economies were possible given the health board's open-ended financial commitment with GPs. GP services are 'demand determined' in the sense that, by and large, the level of service provided is not susceptible to administrative control.

Finally, in the case of community health services, since staff levels were already so low, savings could not be made. These services, the 'poor relation' of the NHS, still had to be brought up to standard. Various 'Good Housekeeping' measures were discussed, similar to those on the list compiled by Alpha - heating, fuel, electricity, postage, telephones, stationery, and so on. No conclusions were reached on possible action in these areas.

The matter of savings was pursued some days later at one of Beta's standing committees (ie the HPC), which was concerned with the control of expenditure with particular reference to staffing. A report was circulated by the AEG based on its joint discussions with the two DEGs. Items in the 'Good Housekeeping' category were not dwelt upon
since any savings accruing would be minimal. The chairman was more concerned to discover why the AEG's report indicated that it might not be possible to scrutinise every vacancy that arose. The Secretary explained that the AEG could not sit in judgement over, for example, every nursing appointment. If one attempted to do this, one would have to adopt the procedure for all categories of staff and examine every appointment. Moreover, there were practical difficulties in maintaining services while a scrutiny was being conducted. For a start, delays would be inevitable. It was suggested that a blanket approach was inappropriate and that a more careful look at particular vacancies should be undertaken. There was a slight rift between the Committee and the AEG over the best policy to pursue. The HPC chairman's preference was for a scrutiny of every post that fell vacant, to which the Secretary responded by suggesting that this was a task for the multidisciplinary groups below the districts, composed of heads of departments. The chairman concluded by saying that when someone departed, perhaps it would be possible to look and see if the board could cope without him/her. Improvements in the service depended upon a watch being kept on the staffing problem, since this area absorbed the bulk of available resources.

The overall consensus in Alpha and Beta was that the scope for savings was limited, although the attempt to throw up some had to be made if only as a kind of symbolic gesture to show that managers were in control, ie were managing. But, privately, perhaps occasionally publicly, few officers
were sanguine about the outcome of these endeavours. For example, the CANO in Beta did not think that the review of existing resources would reveal much slack,

since a large part of the budget consists of wages and salaries. It's an area which is going to be difficult to save in. I think we have handicapped the area by not allowing the district teams to have the right to reinvest any savings. This is what would motivate them towards savings. I see this as a district function. My colleagues, however, particularly the Secretary and the Treasurer, felt that this was not acceptable. They would wish to reserve the right to direct savings to where the need is greatest. I can understand their thinking but I think the price you pay for that sort of safeguard is a diminution in motivation and you can say goodbye to savings.

The Secretary in Beta agreed that over savings there was a problem with incentives, but, in his view, it was an area matter to allocate savings and districts should not be encouraged to retain them. Nevertheless, he appreciated that the districts would simply disguise savings 'so we don't hear about it. A small sum can be 'cloaked' quite easily'. The Secretary reflected that things might have been different if there had not been any districts. As Chapter 8 showed, he was no great supporter of the district idea, at least not when applied to a medium-sized board.

The districts in Beta were ambivalent in their attitude to savings. One DFO said:

If we make sizeable savings the area will redeploy because they know the priorities of the area. I know ethically it's right but when you are going to a department (to request savings) an incentive is necessary ... . It's back to the kid with the sweetie.
The DA in the adjoining district thought that 'the area of savings is a dubious one the way it's being worked'. The district had managed to save £20,000 on security officers who were considered to be unnecessary. The AEG had approved the saving but because of possible overspending by the district in Year 2, it refused to make a decision as to whether the district should receive the money for what it proposed to do, and was holding onto the saving until the accounts had been made up at the end of the year. In the DA's opinion, this might act as a deterrent on functional management, or it could mean that 'savings are effected but not divulged'. This would happen despite the Secretary's attempt to make functional heads understand that it was a national health service irrespective of whether they were responsible for a functional part of it, and that savings should be used for the betterment of the service wherever the greatest needs lay. The DA was sympathetic to the Secretary's point of view, but could see it 'having a deleterious effect over the whole range of functional management'. He explained:

I think it would be inherent in anybody to protect their own management area. If I am a domestic manager, for example, and I can see savings accruing in the domestic services, having already made an application to the DEG for an increase in staff to augment domestic services elsewhere, then what's going to happen? The only protection we've got is through the finance department where engagement forms are scrutinised. The finance officer is going to be the person who will act as arbiter. I feel it's my duty to know about savings, but unfortunately I'm sympathetic towards the heads of departments. If a district building officer can save a labourer and he wants a joiner, then is he going to go all out to save his labourer under the area's approach to savings? I'd like
to see the functional managers being rewarded for savings.

The DA, however, appreciated the dilemma in which he found himself. For example, he was able to see that

if the physiotherapists are short, or if a chiropractor or a health visitor is needed in the community and we haven't got money for them, if we can save on a labourer or a domestic the money released could perhaps be better utilised in the community. I can see from my point of view that I would be managing better if I was to direct the savings towards these community developments.

Part of the problem, as the DA saw it, was the necessity for the district to put their recommendations, with an explanation of how they were to be financed, to the area.

When you've got another tier who might say that a district nurse in district 'Y' is the priority, then I begin to get even more sympathetic towards my own district ('X'). It's cold comfort to save within your own sphere and be commended on the saving but not to get any betterment of that saving within your own sphere. If I can see savings accrue as a manager I should be hard-hearted enough to say to that functional manager, 'look, you've made the saving but there's a crying need for a dental surgeon in district 'Y'. I think that's where the money should go'. I can see the global picture but I think functional managers must be self-centred. They're trying to improve efficiency and are getting no reward. As a manager I don't want to be selfish - I just want to get the best for this district. But then I'm not the total authority.

The Secretary in Alpha was also aware of the incentive problem and savings.

By and large we've left the districts to get on with their own budgets. (But) I think we'd be a bit concerned if, say, a DEG saved over £20,000 and then used it to develop a service. This situation hasn't arisen yet but I think we'd have to look at it. Developments of the service through additional staffing require area approval. I think we may wish to get more closely involved if only because if we don't there's this danger - that we're saying to the AMC and others that we
don't mind doing A, B, C and D, but then if a district goes and does something quite different, somebody will say something. It is area policy that matters, not district (policy). There are two incompatible things here. One might say, on the one hand, that the area knows the overall situation best of all and for that reason we should feel free to decide that if one district makes savings, the most urgent situation might be something in the other district; on the other hand, there's the point about having a carrot. I'm not sure how you reconcile these. Apart from the dilemma over incentives, which reflected itself in an ambivalent attitude on the part of those responsible for managing health services, there were other obstacles to achieving savings. A DNO maintained that effecting savings was far from easy, 'despite the claims and rhetoric from the SHHD'. She explained that there was a deficiency on the nursing side and numbers could not be reduced; rather, it was 'a case of increasing them'. Furthermore, the ready availability of development monies over the years had tended to disguise the obstacles to savings, a point made by the DA in district 'Y'.

Up to this year we've all got so used to having this percentage development allocation - we've sat back, seen how much it is and then it's back to this business of a little to him and a little to that. This is psychologically bad. There's no incentive to examine the existing pattern of work; no incentive to save. (The) new situation might lead us to try and make better use of our existing resources. In this district we've reorganised our vehicle maintenance arrangements (which) will save up to £4000 per annum.

The CANO in Beta shared these observations, commenting that development monies have hitherto been easier to come by than better bed occupancy. This is something we've started wrestling with (but) not particularly successfully up until now because as soon as you start querying bed occupancy figures you're thrown back on the medical right to dictate
treatment. The only way one can hope to do anything very quickly there is through building up good informal relationships with the AMC and persuading them to sit in judgement. I can't see them doing that very readily. We've got hospitals running at 40% bed occupancy which is an absurdity. It's very difficult to gain medical agreement to discussing such things. We've reached that inasmuch as the AMC chairman has agreed that this is a function the AMC should undertake. I can't say I'm optimistic about any big results in terms of savings. I think that there are other ways of getting hold of money for developments, including this important one of looking at how we're using existing beds, nursing time, etc. I see it as a long-term project rather than as something which will help us out in our present economic difficulties.

The Treasurer in Beta expanded on some of these points. With respect to those parts of the service which are under-financed, for example, mental deficiency and geriatrics, 'the position cannot be changed without developments, whether they be nationally financed schemes or developments decided by the board'. Although the amounts saved by both districts were worthwhile, they were not large in terms of what the board was accustomed to for developments. The problem was that for a proportion of total occupancy bed days of, say, 25% in general hospitals, 50% of expenditure (ie half the total hospital running costs) had been incurred. At the opposite end of the spectrum were the MD hospitals with a proportion of total occupied bed days of 37% which consumed almost 20% of the total hospital running costs. The position was slightly better for psychiatric hospitals (27% bed occupancy as against 18.7% of expenditure), better still for convalescent hospitals and geriatric hospitals, although none of these services fared as well as general, acute services. The Treasurer confirmed
that
the thinking nowadays is that this imbalance
will need to be rectified. There is no immedi¬
ate solution to this. It can only be a
gradual process as monies become available. We
now come to the general situation of priorities.
This type of examination of expenditure relative
to use of resources highlights, or should help
to highlight, how you're going to develop your
priorities. The mental health field warrants
special preference as well as the geriatric
field. These parts have been traditionally
under-financed compared to the acute side of the
service. One would get into difficulty if one
said, 'well let's move across resources from the
acute field to the long-term field'. How
politically acceptable would that be if you were
radically cutting down staffing and the service
in hospitals X and Y with a view to providing a
better service in hospital Z?

To achieve a dramatic reallocation of resources was not, in
the Treasurer's opinion, within the bounds of reality - it
would not be acceptable to the population as a whole, let
alone the professions involved.

It is frequently alleged that many of the problems over
change, or more 'rational' resource-use, stem from 'tech¬
nical' deficiencies such as lack of information, or the
existence of the wrong kind of information. While there
may be information gaps, the CANO in Beta did not perceive
a lack of information to be a major obstacle to change.

The CSA and the Department have been churning
out bed occupancy figures for many years. The
medical profession receives them; some of
them they receive and we don't, not even the
CAMO. They're put in a drawer or the waste¬
paper basket and that's it. There's an un¬
willingness to use such information. It gets
back to medical power based on the theory that
the medical profession works in isolation. It's
a political/professional problem rather than a
technical one of lack of information.

If one were to argue that the problems presented by avail¬
able information, like bed occupancy rates, were technical
in character, then one would argue that such data were of the wrong kind. That is, one could argue that information is deficient if it fails to engage people's interests in ways they think (or can be brought to think) are relevant. Hence bed occupancy figures are figures churned out for routine administrative/monitoring purposes, and doctors are unable to see how such figures can help them gain insights into the nature, or context, of the effects of their work. Yet, the CANO's remarks suggest another interpretation, one which was discussed in Chapter 4 where the view that incremental decision-making was the outcome of poor information, or the wrong kind of information, was questioned. This could well be the case in particular areas, but what this perspective has tended to overlook is the political and organisational environment in which information is used. Information is power and will be employed, or ignored, depending on who stands to benefit from its use, and who stands to lose. In the specific example of bed occupancy figures, for many specialties these might suggest that action was needed to improve performance, or to adopt new working practices. Many doctors, quite understandably in view of their background and training, see information which carries with it these sorts of policy implications as management tools designed to weaken their autonomy as individual operators. It is, if you like, a further example of the manager's conception of 'rationality' (ie what is best for the organisation as a whole) versus the clinician's conception of 'rationality' (ie what is best for the patient, and the doctor's ability to practice
his skill). This is not to imply that progress towards a 'middle way' is unattainable, but merely to stress that the availability and quality of the 'right' kind of information will not, by themselves, be sufficient. The existence of administrative politics must be recognised as an important factor in how information is used in any given situation.

If any scope existed for savings and/or reallocating resources, it lay in the hospital service. Community health services offered no scope because, according to the CANO,

the resources already deployed there are less. The health visitor and district nurse ratios are fairly low in this area, and we have inherited problems in relation to them. So there's very little room for saving. Anything that's saved in the community requires to be redeployed there. The community will remain at a standstill over the next few years unless we see that as being the priority with what little monies we get. But then our priorities have, in a sense, been decided for us inasmuch as the sum we will be getting is very small. We're already committed by previous BoMs to developments which we'll have to attend to. Last year the developments were spent for us by board overspending. This year they will be spent for us (we haven't enough money to do it I don't think, but they would have been spent for us) by the opening of two converted huts which are the orthopaedic surgical unit, the plans for which were passed and the whole thing under way before 1 April 1974. So the bulk of our development monies (at least 50%) will be, or would have been, committed to this project. As it's costing £90,000 to open the huts, and as we have only £60,000 approximately, there'll be a delay.

The CANO in Alpha suggested reasons why savings were difficult to realise even in situations where one might expect to find them (eg hospitals).

We've just introduced ward hostesses in hospital X, and they're doing work which was previously done by nurses. You would think right away that you could reduce your nursing, and give that money to ward hostesses. In actual fact,
we don't think we could do this at all because we thought there were not enough nurses at hospital X. The development (ie the introduction of ward hostesses) has helped the nursing situation, but it hasn't given them too many nurses. Now this may be because the health board has different standards from the old BoM, or it may be they've more money to spend, or they've allocated more money to hospital X than the old BoM did. It's very hard to get a saving introduced.

The CANO cited another example which concerned sterilising centres.

The nurses used to stretch gauze, make the gauze, and do all the sterilising. You would think that because they are getting dressing packs they should be able to economise on nurses' time. (But) you never see any saving of any great proportions, that is, to the extent that nurses are standing around doing nothing. They are perhaps talking more to patients. It's very hard to shift the money. On paper it looks good but it's not so easy in practice.

This brief discussion of the scope for savings in Alpha and Beta, and the obstacles encountered by them, may be summed up in the words of a DA in Alpha.

Although people say there are savings ... unless at the end of the day you can reduce your staffing it's not an actual saving. Strictly speaking, there is no reason why we shouldn't look at any service and ascertain whether or not it is effective. If it's not effective then it's the responsibility of management to do something about it. It's not always possible because we're in a social, political climate.

By 'social, political climate', the DA was referring to (1) the existence within the NHS of numerous professional groups, in particular clinicians, who did not always share the administrators' commitment to rationalise existing services and who, therefore, had to be persuaded of the benefits of doing so; (2) the need for officers to respond, at times quite rapidly, to ever-changing political moods which emanated both from below (eg the public) and above (eg cir-
culars from the SHHD), examples being the national emphasis on community care, and the requirement to freeze management appointments in an effort to contain administrative costs; and (3) the difficulties in effecting savings, particularly where incentives were lacking and there was conflict, usually latent, between area objectives and district objectives. Some of these themes are taken up again in Chapter 13.

12.3 The Way Ahead

In addition to the official documents dealing with constraints in expenditure, one other official document helped to shape the decisions that were taken in Year 2 on allocations of DF. In April, the SHHD published a memorandum\(^{(3)}\) on priorities in the health service for the next four years. Its purpose was to provide a loose framework, or set of guidelines, to assist health boards with their resource-allocation tasks.

The memorandum did not arouse the same controversy as its English equivalent - some of the reasons for this have been explored in preceding chapters - although it was concerned with similar themes. Nevertheless, it represented an innovation for the SHHD, for, as an Undersecretary of the Department explained, the SHHD tended, on the whole, to react to events and pressures of a political nature, and did not operate within a strategic plan for the NHS. The memorandum was a step in this direction, although even this step was itself the outcome of political pressure being applied because of resource constraints. However, it was the
first document dealing with the NHS in a comprehensive way. Other documents, like the 'Blue Book' on services for the mentally handicapped, had concentrated on specific services. The memorandum identified five priority areas: (1) the promotion of health care in the community through the improvement of primary care services and community health services; (2) the development of health services for families in areas of multiple deprivation; (3) a lessening of the growth rate of the acute sector of the hospital service; (4) the continuation of improvements in hospital and community health services for the elderly, the mentally ill, the mentally handicapped and the physically handicapped; and (5) the encouragement of preventive measures. The publication of the memorandum at this particular time was a direct result of the 'serious economic situation' which had necessitated reductions in the NHS' growth rate, and the document was perceptive in its recognition that the availability of DF had 'removed the stimulus to make a comprehensive appraisal of priorities across all the various sectors ... . One effect of the present economic situation is to make the necessity for such an appraisal more explicit'.(9) This view, as mentioned above, was shared by many officers in Alpha and Beta. The memorandum went further and recognised that 'if there is to be any marked progress in one sector it can only be achieved by securing economies elsewhere'.(10) The opportunity for rationalisation lay, as noted above, 'mainly, though not exclusively, in the hospital field, particularly in the acute and mater-
nity services, which account for some 40% of the total Health Service expenditure'.(11) The memorandum stressed that it was not the Department's intention 'to impose a uniform pattern of development regardless of local circumstances', (12) a strategy in line with the Department's perception of its relationship with health boards. (13) But the Secretary of Alpha regarded the memorandum as more than simply an advisory document (or one merely 'setting the emphasis', as a senior civil servant expressed it).

There are things in the document such as, 'the Secretary of State expects the boards to do something'. To my mind that's very close to an instruction. I'm not saying that one must follow it exactly because every area will look at its own special needs. At the end of the day the Department can exercise a strong controlling role. If anyone wants to go along a road different from the ones outlined in The Way Ahead, they've got to be really justified.

Not surprisingly, perhaps, the memorandum did not reveal anything to officers that they did not already know. The Secretary of Alpha did not think his board would need to change direction much.

Even if one looks at our building programme, the big schemes that we've got are essentially long-stay beds. We've got a healthy health centre programme. We're set on the right path. I don't know if the board has ever made it explicit, but geriatrics is our top priority.

The Secretary thought that the memorandum was not so much saying anything new as 'making things explicit'. The Treasurer of Alpha was less charitable, and maintained that although the memorandum had been useful, its impact had been minimal because 'we were thinking along these lines in any case. The document is two to three years too late
in some ways'.

The memorandum appeared to have a greater impact on the policy-making activities of Beta, although this was not reflected in the decisions on priorities for DF (see below). For example, at a meeting of the board's PRC shortly after the document's publication, there was some concern about the schemes contained in the board's Centrally Financed Building Programme (CFBP). The memorandum had made it clear that there was to be a strong shift of emphasis towards improving services for the elderly and mentally disordered, particularly in relation to the types of schemes which would be acceptable to the SHHD as part of the CFBP. The Department had pointed out in respect of Beta, that the board's CFBP contained no schemes for the development and improvement of long-stay services, and had stated that evidence of priority being allocated to this field of service would be welcome. It was clear, in the PRC's opinion (guided by the chief officers), that the board would be required to demonstrate its intention to make substantial improvements in the fields of geriatrics and mental disorder, if important schemes, such as the redevelopment of hospital X (for acute services), were to be accorded priority by the Department. It is worth noting that this particular development was the board's top priority by way of capital schemes; it had remained at the planning stage for years and was eagerly awaited by officers and board members alike, all of whom were anxious to see results. It was feared that if such a demonstration was not given by the board, then it was possible that the schemes currently given a high priority
on the CFBP could be deferred by the Department, and the money allocated elsewhere leaving the board with no centrally financed projects for perhaps the next ten to fifteen years. To prevent this from happening, the officers put forward three schemes for inclusion in the CFBP, all of which had been inherited from the former BoM and RHB. They would assist in redressing the imbalance in geriatric beds between the two districts, and, insofar as these, or similar, schemes would lead to an overall increase in numbers of staff employed, it was hoped that a special allocation would be made by the Department to cover additional running costs. The only centrally financed scheme at present on the CFBP which related to district 'X' was a new maternity unit which, like the redevelopment of hospital X in district 'Y', went against the suggested direction of health policy outlined in the priorities memorandum. However, it was decided that local need required that this project remain a priority.

Officers in both boards were aware of the difficulties in pursuing the recommendations in the memorandum. The Secretary of Alpha explained that one problem with building up the preventive and community services was that boards did not possess control over GPs. Although he was hopeful that the development of health centres would make practice more attractive in particular areas, the fears of many doctors over entering health centres and giving up their own practices had to be overcome before real progress could be made. Another problem, which the Secretary pointed out, was that building up general practice through
a health centre programme would not necessarily make for less work for hospitals. On the contrary, 'it might generate more work for hospitals because more referrals may result from such an expansion'. Therefore, the SHHD must be careful not to delude themselves that improved primary care services would in all cases relieve the pressure on the hospital service. The paradox that measures ostensibly advocated to reduce costs, or, at the very least, to contain them, might in fact have the opposite effect and actually increase costs also extended to the measures being considered in both boards to effect savings.

The memorandum posed other problems for health boards of a more profound nature. Most significant, perhaps, was its emphasis on the need for improvements in the 'Cinderella' sectors and in the community health services, an objective which, to some extent, clashed with the Department's concern over increasing staff levels. It was pointed out in the last section, on savings, that a vital area in any attempt to control health service spending is staffing since it accounts for the bulk of available funds spent on the NHS. As a direct consequence of measures aimed at controlling staffing developments (reviewed above), those projects with no, or very few, recurring revenue costs were favoured over-and-above projects with large recurring revenue costs, regardless of what the particular projects were trying to achieve. According to the Treasurer in Beta,

obviously in a period of great restriction of running costs, capital schemes which might be
very desirable in themselves but which attract considerable additional running costs will of necessity have to be put aside unless when the submission is made there is built into that submission identifiable savings. Otherwise it is out. This situation could mean a channeling of capital on certain types of activity only.

But there was a conflict between this policy aim and the equally important one of improving community services. Long-stay services would suffer, too, unless there were centrally financed schemes which would bring with them additional funds for running costs (these funds were only available with centrally financed schemes, not with a board's ordinary building programme for more modest schemes). Moreover, both long-stay services and community services could only be dramatically improved with additional staff. The Treasurer in Alpha confirmed that the constraints in staff recruitment adversely affected community services which were labour-intensive. The only institutional facilities in this sector capable of bringing with them additional development monies were health centres. But financing arrangements for these changed in 1975. Up until then, special allocations had been made for health centres. Now, however, they were to be included in the national programme or the ordinary capital programme as appropriate. This change in policy had consequences for Beta, as the CAMO pointed out. It could mean that only big hospitals or institutions will bring extra money to run something new. Health centre X, which we inherited, was centrally financed but we had to find the funds to operate it. There was no additional allocation. (For community services) you're dependent on the present system of allocation by capitation (ie annual DF).
The dilemma was that while an emphasis was placed upon the improvement of community and long-stay services, the resource situation made it extremely difficult to do very much about achieving this objective, despite the exhortations of the memorandum. Moreover, as the last section on savings clearly showed, the obstacles to switching large amounts (which, had this been possible, would have greatly benefited the priority areas) were formidable. The paradox of all this was that the money available for centrally financed projects was for schemes located in the hospital services, and although some of these were for long-stay patients, the community services were largely excluded from access to these additional funds. Instead, they had to compete with other developments for a slice of the limited DF available (see next section). Consequently, the situation of 'low growth', while widely heralded as an opportunity to reappraise priorities and to shift the direction of health services towards community care and away from excessive hospitalisation, in fact worked in such a way as to contribute to the very imbalance it was aimed at correcting! Of course, this contradictory policy stance was unintentional, being the outcome of conflicting political aims, but it was, in the circumstances, inevitable. It is not possible to operate concurrently two irreconcilable policy objectives without policy stress developing.

On the whole, board members found the memorandum useful, perhaps more than many officers did, since it offered them a set of guidelines by which they could measure the progress of their own policies.\textsuperscript{15} Beta, for example, devoted
almost two days to discussing the implications of the document for future board policy. The Chairman had been troubled for some time that board members were not really formulating policy at all. In large part, this was due to the board’s commitment to inherited projects.

There was not the money nor the occasion for us to start looking at what we could do ourselves. Now within the last three months, mainly as a result of the Secretary of State’s memorandum we were asked to look at our priorities in the medium-term and we spent 1½ days doing that. We decided, in line with the Secretary of State’s wishes, to develop the long-term care aspects of the health service and the board is now laying down broad principles on what we’d like to do and what we’d like to see. It’s up to the officers to implement these in due course. Prior to The Way Ahead we had tended to accept what had gone previously. The memorandum triggered us off.

It is worth noting that board members seemed unaware of the possible contradictions within the memorandum (examined above), and were by no means dismissive of it in the way some of the officers were. But then, board members looking for something to grasp which would give substance to their role were not likely to be easily put off. Officers were more aware of the intricacies of the problems which the memorandum set out to tackle, and the fact that the document treated the problems in very general terms rendered it less useful to officers.

Alpha’s PRC discussed the memorandum in much the same way as board members in Beta although there was perhaps more agreement between them and the officers as to the applicability of the document’s proposals to the health services provided by the board. Certainly both members and officers (as noted above) accepted that Alpha’s programme was
in line with the memorandum's objectives. Board members simply wanted greater emphasis to be placed on health education.

12.4 Development Funds - Allocation Process

Despite resource constraints, both Alpha and Beta received small amounts to allocate on new developments. They would have had larger sums but for the pre-emption of the bulk of available DF as a result of national policy decisions. There were two of these; one concerned the extension of the Family Planning Service in hospitals, authorised in circular 1975 (PCS) 79, to include contraception, vasectomy and female sterilisation which had not been provided before except on medical grounds, and the other involved the implementation of the junior doctors' pay award. Health boards had no control over these decisions and were statutorily bound to implement them as agents of the Secretary of State. Neither of these pre-emptions was popular with officers or board members who, naturally, resented their inability to decide their own priorities with the monies available. For example, the Chairman of Beta said that in the case of family planning and the junior doctors' award, 'we would never have intentionally put our money towards them, but we had no option'. He added that he 'would like to see a situation where we do not have government making decisions which involve the commitment of our funds without our being a party to them'. The Secretary of Alpha was more circumspect in his remarks. Looking ahead beyond Year 2 he hoped that not so much of the growth rate would be pre-empted by national decisions. 'We hope next year
we'll have a fairly free hand on how to spend it, albeit
within the guidelines laid down in the memorandum'. He
explained how

pay awards have historically been funded by the
Department. The Department claims that the
junior doctors' pay award is self-financing.
This is not so. What's happened is that every
board has had to use up half or more of its DF
to pay for it.

Although Beta's provisional revenue allocation for Year 2
would have provided for a growth rate of 0.8% (most of
which would have been pre-empted), the final revenue allo-
cation (of which the board was informed in early April)
allowed for development monies of the order of 1½%, of
which £184,000 remained to be allocated, the rest having
been deducted to cover the full year effect of developments
authorised in Year 1. The board decided to reserve almost
£2 million of its total revenue allocation of £21,692,000
for pay awards, prices, and so on since these had to be
met from within the board's own resources.

The development allocations for Year 2 (Beta) were approved
by the PRC in May and totalled £134,000, leaving £50,000 or
so for further developments. The sum of £134,000 was
sufficient to fund about six developments, which had already
been approved in early March, and two of these were pre-
emptions (ie national policy decisions) which together came
to £74,000, well over half of the available DF. The largest
pre-emption, £65,000, was a result of the junior medical
staff's pay award, and the other for £9,000 was in respect
of family planning in hospitals. Of the remaining new
developments, by far the most costly was a proposal to
spend £54,000 on the development of an orthopaedic surgical unit at the Royal Infirmary located in district 'X' (this development is referred to hereafter as Ward Z). The AEG had long been anxious to tackle the problem of long waiting lists for orthopaedic surgery which was why this development was being given top priority. The remaining DF were split between other small developments, including a health clinic extension and the staffing of two health centres. The sum of £54,000 for Ward Z was just over half of the total figure requested by district 'X' in respect of opening the entire ward, as distinct from part of it. The cost of a new consultant post in orthopaedic surgery, if approved by the Advisory Committee on Hospital Medical Establishments, would obviously be a first charge, around £9,000, on the allocation of £54,000, thus reducing available monies to around £45,000. For the new unit to function, a consultant post was essential. The AEG had sought the views of the AMC and the Area Nursing and Midwifery Committee on the development proposals, and both committees considered that the opening of Ward Z for orthopaedic use should have priority in the allocation of DF. The interesting arguments in Beta occurred over the fate of the remaining free monies which amounted to a little over £50,000 (the remainder of the £184,000), and led to heated discussions in the AEG. Perhaps the very size of the balance of DF served to intensify, and bring to the surface, latent frustrations over numerous deficiencies; after all, it was almost certain that the board would not receive any
further free monies and, if by some stroke of luck it did, these would be for non-recurring purposes. At its May meeting, the PRC asked the AEG to make recommendations in respect of further developments to be financed from the balance of £50,000 approx.

The AEG met shortly afterwards and agreed that the DEG in district 'X' should submit an estimate of the cost involved in opening the remainder of Ward Z for orthopaedic use. The AEG further agreed that if the figures submitted proved satisfactory, then consideration would be given to making a suitable allocation to district 'X' for this purpose and, in the event of there being a balance remaining from the total of £50,000, heads of departments would be asked to submit their priorities for funding from this balance.

The choice before the AEG at its next meeting two weeks later was whether the remaining DF should be allocated to the orthopaedic unit, or whether the money should be put 'up for grabs'? It took almost one hour for the Group to reach its decision. The case in favour of allocating the funds to Ward Z was a powerful one since, from the start, the development had been the board's first priority. Up until then it had only been possible to open part of the unit with the funds available, but the additional sum of £50,000 or so now to hand would enable the entire unit to become operational. The Chairman of the AMC (present throughout the AEG meeting) was firmly in favour of the money going to this development, which was hardly surprising in view of the interests he represented. Since the
board now had Ward Z, his preference was for making a good job of the unit by opening it completely. The members of the AEG shared his view, although the CANO added a proviso that he was in favour of Ward Z being developed on the understanding that there would cease to be extra beds in existing wards, a practice which was placing a strain on nurses who were unable to provide adequate cover for these beds. Unless action was taken on this, he would have to refer the matter to the board and the DF would have to be spent on extra nurses to provide additional cover. There would be no need for this practice to continue once Ward Z became fully operational as it would make extra beds available. The Chairman of the AMC assured the CANO that action would be taken to end the practice of which he complained.

Opposition to the proposed allocation of the £50,000 came from the CADO, who was concerned that nothing was being done for dentistry with the result that a serious situation would remain. He resented the fact that £50,000 might go entirely to Ward Z, especially when there were problems outwith the unit and the medical profession for which the AEG was responsible. In the CADO's opinion, the DF should be put 'up for grabs', and, in this way, the dental service might be able to lay its hands on a portion of the funds. The CADO maintained that the AEG attached insufficient importance to dental care, a charge denied by members of the AEG who argued that Ward Z was being singled out since it was felt to be where the priority lay.
Members of the Group proceeded to impress upon the CADO that dentistry was not unique in suffering from deficiencies. There was equal concern in other sectors; for example, because of a shortage of anaesthetists, there was a two-year waiting-list for operations. The CAMO said that they could all produce great lists of staffing requirements, while the Chairman of the AMC went further and stated that no one died from a dental condition, whereas he observed patients dying daily from lack of resources. The CADO questioned whether death should be the sole criterion which governed resource-allocation decisions. The CAMO then advised the CADO that he should correct any deficiencies within his own resources as indicated in The Way Ahead, to which the CADO responded by saying that this was impossible, since one could not reallocate to a non-existent service; in any case, he added, the memorandum argued for more resources to be directed towards the community and away from the hospital service. It did not appear that the AEG was following these guidelines, at least not if one was to judge by this particular decision concerning DF. The CADO illustrated the dilemma facing dentistry with an analogy:

Other disciplines (besides dentistry) have problems because of a historical legacy, but not to the same extent as dentistry. If two men pay income tax, one on £1,000 per annum and the other on £10,000 per annum, if the man with £10,000 loses £2,000 because he has a 10% cut, that's inconvenient but he's still got £8,000. But if the man with £1,000 loses £200, he has only £800 to live off. That's the picture for dentistry.

At this point in the discussion, an impasse had been reached between the AEG on the one hand, and the CADO on the other.
The CANO, in an attempt to resolve the differences of opinion, explained to the CADO that the most he could expect was to have his views recorded in the minute, but not his dissent since he was not a member of the AEG. To settle the matter, the Secretary took a vote, from which the CADO was excluded, to determine how the DF should be spent. The AEG voted unanimously in favour of going ahead with the development of Ward Z. The Secretary wondered if further monies were likely, but the Treasurer could not foresee an additional allocation. All the DF had been allocated, including this 'fag end' of £50,000. The Secretary wondered, therefore, if there was much point in requesting submissions from the two districts. The Treasurer thought that proceeding with such an exercise might create false hopes and, in any case, there remained a catalogue of outstanding requests from Year 1. The CANO, however, thought it would be a worthwhile exercise to find out what the priorities were in the districts since they tended to change from year-to-year. People should be able to make the AEG aware of their needs, and if requirements were not collected and, therefore, not known, it might be embarrassing in the event of funds unexpectedly becoming available. Obtaining development lists would be an updating exercise which in itself was valuable. It was agreed, therefore, that although no funds were available at that time for further developments, the two DEGs should be requested to submit lists.

After the meeting during informal discussion among some of
the officers, the Secretary agreed that the development of Ward Z went against the advice contained in The Way Ahead, although, in fact, the decision to proceed with the development had effectively been taken four months previously, ie well before the memorandum was published. Furthermore, there was, as mentioned earlier, an acute shortage of orthopaedic beds with long waiting-lists for treatment. A report\footnote{17} completed by a working party of board members and officers (half the membership was composed of board members) in January of Year 2, was not complimentary about the state of orthopaedic surgery in Beta. According to the report, it was clear from the statistics relating to bed occupancy and waiting times that the position regarding delays in the treatment of inpatients in this field was unsatisfactory, and, furthermore, that the primary cause was a shortage in the number of beds available for the specialty. The number of persons requiring orthopaedic treatment, said the report, had increased over the years partly as a consequence of the increasing number of road accidents. Although the report's finding was probably one of the factors which led officers to allocate all available free DF in Year 2 to the Ward Z project, it is perhaps significant to note in this context that the report did not advocate this line of action as the only solution to increasing pressures. It noted that although the total number of beds available was insufficient, the factor which caused the shortage to arise most acutely was the occupation of many orthopaedic beds for long periods by geriatric patients who no longer required orthopaedic surgery or care of this kind. The
working party felt that if such patients could be transferred to geriatric accommodation (it will be remembered from earlier chapters that the ability to ease transfers between the hospital and community sectors was a primary aim of an integrated health service), the unsatisfactory position regarding the waiting time for orthopaedic surgery would be alleviated. In the event, the working party's advice was not followed, one reason no doubt being that geriatric patients no longer in need of general medical services could not be discharged because of a lack of suitable alternative facilities either in the hospital sector or in the community. To a great extent, the solution of this problem depended on the success of inter-agency cooperation between health and local authorities. Previous references have suggested that this left much to be desired.

Despite the working party's report with its alternative policy option to the one pursued by the board, the Secretary was anxious to stress that the decision had not been inevitable but had been a calculated one. Had the AEG felt that the priority lay elsewhere then Ward Z would not have been staffed. In the circumstances, it had been a difficult choice for the AEG and the priorities memorandum had prompted the Group to have a re-think. The AEG spent two days discussing informally whether Ward Z should remain a top priority in the light of the memorandum and, as the above account of the final meeting on the matter has shown, it decided the development proposal should stand. The CANO pointed out that the SHHD would not prevent the devel-
development from going ahead, and added that, in any case, the memorandum was in many ways too general and too vague, and omitted to include sufficient detail. The implication seemed to be that for the realities of decision-making the document was not especially relevant, although as a general, public statement of political intentions vis-à-vis future health policy it was acceptable. The CANO went on to express sympathy for the CADO's position, claiming that in many ways he was right: Ward Z was a hospital service development and represented another blow for dentists and community health services. Presumably, although the CANO did not mention this, the development also made it more difficult to move in the direction suggested in the working party's report in its comment on orthopaedic surgery. However, perhaps in confirmation of this, the CANO maintained that when so little money was available, decision-making and priority-setting became arbitrary, a view which contrasts sharply with that expressed by many officers (see above) that a period of economic stringency provided an opportunity for rational reappraisal. In the CADO's opinion, priorities were decided on the basis of 'custom and habit', and the hospital service was receiving funds per usual. This seemed to him to indicate that there was no real integration in the NHS; people were out to get what they could for themselves.

At the PRC meeting at the beginning of June, a report was put before it from the AEG notifying the committee of the Group's recommendation to allocate the balance of DF to Ward Z. The report noted that 'all of the balance of
development from the current year would be required to open Ward Z fully and therefore no funds would be available for any further developments'. The report also recorded the CADO's dissatisfaction with the way in which dental services had been neglected in allocating monies. The PRC agreed that the balance of development monies for Year 2 should be made available to open the remainder of Ward Z.

As mentioned above, both districts in Beta were asked to submit revised priorities in respect of their requests for DF, in order that the AEG would have an up-to-date appreciation of the situation. Both DEGs were aware that their lists of requests would end up as little more than paper exercises since the DF did not exist to fund them. Nor was it likely that funds would materialise later in the year; the days of the 'Christmas handouts' were over in a period of restraint. Nevertheless, in the words of one DA,

> it behoves us as managers to have priority lists of developments if suddenly there is an influx of money; it may be given to us in a hurry and if we're not prepared for papers to be distributed for discussion and priorities determined, then I would suggest we're not managing. We've got to update all the time.

The districts in Beta undertook to revise their priority lists in July. In a normal year, they would have submitted their proposals much earlier for approval (cf with allocation of DF in Year 1), but in Year 2, not only were district requests submitted late in the year, they were also submitted after the AEG had allocated the small amounts available. The usual practice of district requests being reviewed by the AEG prior to allocations was
reversed. In the event, the lists prepared by the districts did not achieve much because, in late August, the Secretary announced that no further developments were anticipated at that time. He added that the districts had not made much of an attempt to place their submissions in strict order of priority since this was thought to be a waste of time when no DF were likely to become available. The AEG, therefore, was in possession of a 'jungle of requests'. In September, the DA in district 'Y' confirmed that there had been no follow-up so far to the development proposals submitted to the AEG. He thought that the only hope for free monies lay in savings which would then release funds for developments, although, even then, recurring allocations (ie for staffing developments) were unlikely, since savings would most probably be used to offset overspending and to cover the junior doctors' pay award. Anything left would go on non-recurring expenditure, eg furniture, upgrading of wards, etc.

At the end of September, the Secretary confirmed that no further DF would be available in Year 2. The only possibility was a small sum of nonrecurring expenditure (about £20,000). While other members of the AEG wanted to go through the process of receiving submissions for this amount, the Secretary considered this farcical. In the end, two emergencies swallowed up the allocation, which seemed to support the Secretary's contention that it was a 'hand-to-mouth' existence during this time of financial stringency.
Despite gloomy predictions, some funds did materialise for nonrecurring purposes only. Most of the money came unexpectedly from slippage in the capital building programme which resulted in a shortfall around December, thus enabling the board to reallocate £70,000 from the programme to nonrecurring purposes. As the Secretary pointed out, it's a case of choosing schemes which don't attract running-costs and most of these are self-selecting. The other proviso is that the schemes must be completed by the end of the financial year'. It was essential to use up all available funds since it was 'not good to persuade staff to economise and then be £100,000 underspent'.

The position in Alpha over DF in Year 2 was markedly similar. At an AEG meeting in late May, the Treasurer reported that it was unlikely that recurring DF, achieved by making savings elsewhere, would become available until the autumn. The AEG agreed that, although priorities might alter in the interim, submissions would be sought from the two districts in order to allow extended consideration as to the distribution of funds. The present position allowed no room for manoeuvre since the board was committed to additional expenditure which came close to the anticipated DF for Year 2 (as a result of national policy decisions, and the requirement to fund the running costs of completed capital schemes). Therefore, unless additional funds were made available by the Department, or through savings, the board would not be in a position to go forward with any other developments of the service.
In June, the districts drew up their lists to be submitted to the AEG. District 'A' was not involved in much activity, in contrast to district 'B' which adopted a new approach to staffing developments in Year 2. Instead of the usual practice, adopted in preceding years, including Year 1, whereby the DEG asked for requirements from heads of departments and so on which were then itemised on lengthy lists, usually with a minimum of supporting data, to be sifted through, it was decided that the newly appointed District Personnel Officer (DPO) and District Management Accountant (DMA) should jointly produce the basic information for each development proposal before the lists were considered by the DEG. In a sense, the DPO and DMA were interposed between those delivering the services and the DEG, and acted as filters for development requests.

There were three reasons for adopting a new procedure at this particular time: (1) the DPO had not been in post for long; (2) the DMA had also recently been appointed; and (3) the DPO did not approve of the way in which developments had been handled in the past - the lists reflected what people asked for, and there was a lack of scrutiny of the items requested. Apart from this, the system, in the DPO's opinion, had two further failings: (1) a considerable amount of correspondence went back and forth between heads of departments and district officers, and a development was either hardly supported at all or little information existed to enable a particular development to receive backing; and (2) with the separation of finance and administration, it was necessary to try and match the needs of
finance to the needs of the service. According to the DPO, 'we never had to do this before because at BoM level it (ie finance and administration) was a joint post' (ie Secretary and Treasurer).

The DPO and DMA prepared forms designed to elicit all useful information about a particular request for additional staff, including a fairly exact statement of priority. Heads of departments were asked to state how a particular request stood in relation to other developments for their departments or functions, and were also asked to indicate the repercussions on the service if a development was not implemented. Data were also requested concerning the reasons for a request (eg increase in workload, development of service, change in work methods, or change in regulations/statutory requirements), the cost implications, and details of what duties the post entailed. In addition, heads of departments were asked to indicate any savings that might accrue from the implementation of a development. The aim of this development-processing exercise was to feed the DEG fuller, more complete, information because, in the past, supporting information had tended to be too subjective. In the DPO's words, 'it was not a very scientific process'. The DPO and DMA, by their own admission, were attempting to inject some rationality into the allocation process by examining the lists 'with a fine tooth-comb' before they were submitted to the DEG. The two officers had no executive authority, their task being, as the DPO explained, to 'put the information into a form in order to
advise the DEG. If there's an argument between finance and services then this can only be resolved by the DEG'. The form was designed to fulfil specific objectives. The DPO explained:

I wanted to know what the development was for, how important it was if it was implemented, and how important it was if it wasn't implemented and the implications of this. I really wanted to know what kind of development this was - not just a hazy idea.

The aim was also to find out how much support there was for a particular development. But, according to the DPO, the most important question concerned the effects on the service that might occur if a development was not approved, and, in fact, very few heads of departments had claimed the service would come to a halt without a particular development. In some cases, in addition to requiring special forms to be completed, the DPO met departmental heads and discussed their requests with them, and most had been very cooperative. 'No one thought the forms were rubbish and very few forms were badly filled in. Some people didn't bother replying so I assumed they had no developments'.

It was the task of the DPO and DMA, having gathered all available data, to place the requests into priority categories A, B, or C. Certain criteria were employed to achieve this although none was particularly sophisticated or, indeed, scientific. According to the DMA, in the main it was 'just the strength of the case as presented by the party who was putting forward the case. We grouped them like that and put them to the DEG who had to examine the priorities'. The DPO pointed out that he kept 'assess-
ments muted since that is the DEG's function and their decision. But some of the developments stood out - 90% of the A+s stood out'. He added that some developments, such as radiography and nursing, were hard to assess, although it had not been such a difficult exercise this time because just the A+s were being looked at. The DPO thought that

the bother comes when you get money for the A+s and a bit more besides. Then you've got to decide between the As and even the Bs. This is the real difficulty because you're deciding between services being less good or not being provided at all. We'll have to talk through each if funds become available. The A+s are easy - most of them are on a par.

Despite the attempt to perform more rationally, the DPO admitted that there was a limit to which you can scientifically continue to look at developments. You've got to be as informed as possible and see how much support there is for a development. The problem over staffing developments is whether or not existing staff are fully utilised. These avenues haven't been explored fully enough yet. Staffing norms have a psychological effect in that they provide a goal to work towards and provide some means of objective assessment.

But there were limits on how much quantification was possible in the case of staffing developments. The DPO said that figures had been produced for all professions which were the result of work study reports and O and M studies, and some, like the Aberdeen formula, had 'more clout than others'. Nursing was the most advanced in terms of quantification; in the case of other staff categories, some figures had been accepted and others had not. The DPO said that 'in a small district, a lot of it (ie the
allocation process relating to DF) is sense - you know what's needed, and you can keep in touch on the ground. It's dangerous too because people come to you more often'. Nevertheless, the DPO wanted to be more scientific about staffing by preparing job descriptions in detail instead of just a few general headings. In this way the DEG would be clearer about what DF were wanted for.

The weakest part of the assessment of requests was that dealing with savings to be achieved from the pursuit of developments. The DPO was not sure how much validity to attach to claims about savings. In some cases, developments stood out where there might be savings, eg more ward housekeepers rather than trained nurses could mean savings (but see comment by CANO in Alpha above); but in other cases, eg request for a maintenance engineer, it might be necessary to spend money in order to save some. The problem, as the DPO acknowledged, was that 'you don't really see any savings; it's just a continual process of adding to existing stock'.

Another sensitive area was the selection of information by the DPO and DMA to support each submission. Each item listed carried beside it an explanation of between forty and fifty words, followed by a recommendation, conveyed in about twelve words, from the DPO and DMA. Two examples will suffice to illustrate the format. The first concerns a request for a porter, and in the assessment of need column it was stated:

Essential - present establishment inadequate
to provide 24 hours, 7 day cover. There is no slack for relief purposes and during periods of absences, level of service cannot be guaranteed, particularly the departments such as pharmacy. Recommendation: retain on list for first priority funding.

Alongside a request for three ward housekeepers, it was stated:

To complete the introduction of the service for all double wards and to increase the service in certain wards. Recommendation: while this development is highly desirable and the scheme is successful, priority could be reduced.

The DFO, commenting on the new procedure after the DEG had decided upon its priorities, said that the DEG 'really didn't have all the background information, we only had a summary from the DPO. It may be that we should have seen the detailed sheets that came in'. Of his selection of data for the DEG, the DFO said:

I wanted to say what the development was for, what it was going to do, to try and give some indication of the situation if it was not done, and to try and pin down other points of relevance, for example, recruitment difficulties. For example, we may be desperate for physiotherapists, but my chances of appointing any are slim. Is there, then, any great point in putting money aside for them?

The development lists, prior to going before the DEG, were organised into three sections: administrative and clerical; medical, dental and paramedical; and nursing. Whereas in Year 1 developments had been split between the hospital and community services, in Year 2 there was an attempt at genuine integration between the two services.

The DEG met to consider the development lists in mid-June, went through each item to decide whether it was an urgent priority (A+) and should be referred to the area for con-
sideration, whether it should simply remain on the list (A) and not be referred to the area, or whether it should be a reduced priority (B or C). The Group was well aware that the entire exercise was a paper one only, in that very few requests, if any, would receive funds. Out of a total of 66 requests, 48 had an A priority, 8 had a B priority, and 10 had a C priority. The A priority requests amounted to £207,700 approximately; the B priority requests to nearly £30,000; and the C priority requests to nearly £48,000. All the B and C requests were listed on a separate sheet with no supporting data attached. In the case of the A priority requests, the DFO said it would be extremely unlikely for the district to achieve savings sufficient to enable the funding of all A-rated developments. The hope was for an allocation from the AEG of non-recurring funds which could be used to take on-staff temporarily for a six month period until the end of the financial year, when the money would run out. Obviously, this would be nothing more than a stop-gap measure.

The DEG's primary task was to decide which items were to be referred to the area. Apart from the DPO, also present at the meeting was the CANO who was standing in for the DNO. As in Year 1, most of the developments were directed towards filling gaps in services, and only one or two, like the request for ward housekeepers, represented a development of the service. During the meeting, the DA attempted on several occasions to link particular requests with policy recommendations contained in The Way Ahead. For
example, a request for 3 ward housekeepers at an MD hospital became an A+ priority, despite the DFO's preference for an A priority for one ward housekeeper, and B priority for the other two. The DA emphasised that central policy was aimed at improving services to the mentally handicapped, therefore this particular development was in line with policy. Interestingly, this decision was completely contrary to the assessment of the development by the DPO and DMO (quoted above), who were of the opinion that it could receive a reduced priority.

Over many other requests, the DEG was faced with little option but to give them priority. For example, in the case of one request for additional secretarial assistance it was the old familiar story: a consultant had been appointed and there had been no attempt 'to add on the trimmings'. When it came to the nursing requests, the CANO said that he would not be pushing for increased staffing at one of the hospitals since this had done well the previous year; however, it might be pushed again the following year. A request for health visitors was in line with national policy, so this received an A+ priority.

At the close of the meeting, the DEG had a final list of 14 A+ priority developments, 33 A priority, 10 B priority, and 9 C priority developments. The DPO did a quick percentage calculation on the total number of submissions, which represented a 3% growth rate, ie the normal growth rate for the NHS.

When asked which of the district's priorities was the most
important and what would happen if the district received DF, the DA replied he did not know - he simply could not say at this point in time. The DEG would have to review all the A+ priorities and then decide. It would be far from straightforward. Commenting on the meeting to examine the lists, the DA claimed it had been unreal because no money was likely. Therefore, the DEG was not in a corner. Only when it was in a corner did the fighting begin; otherwise there was no need to take harsh decisions. The DA was sceptical about the availability of savings to enable essential developments to proceed, since real savings involving large sums of money would only emerge in the long-term. Moreover, it was not easy to reach out and put your hands on a particular saving, since savings came in bits and pieces from numerous parts of the service.

In Alpha, no staffing developments were undertaken in Year 2, beyond those already agreed to which had been carried forward from Year 1. There might have been some scope for allocating DF had not a second nursing crisis arisen (the first occurred in Year 1), this time in district 'A', over the summer and autumn. It was reported to the PRC that there had been a substantial increase in hospital nursing staff numbers in the district over the two years since reorganisation. Out of an overall increase of 245 nurses (from 1286 to 1531), 160 were attributable to developments authorised by the board, or to national agreements arising from, for example, the Halsbury report. Of the remaining 85, 60 were funded but were not in post in
April 1974, leaving an unfunded balance of 25 nurses, ie 25 in excess of the figure for which funds were available. The Treasurer stated that, because of his position, his advice could only be to restrict the number of nurses by 25 since any increase over this establishment figure would result in a pre-emption of the small amount of DF anticipated for Year 3. The pre-emption would amount to £70,000 if the nursing establishment were allowed to continue, and this would, of necessity, mean that other developments, including the commissioning of certain capital schemes, could not be implemented.

The CANO, not surprisingly, dissented from this view and supported the establishment figure of 1531, arguing that it was still below the pre-reorganisation establishment figure of 1573, which would entail a further 42 nurses. Moreover, he understood that funds were available to finance this figure, although this now appeared not to be the case. Nonetheless, in the view of all the nursing officers, this original higher establishment figure was needed to provide a reasonable standard of nursing care, although the figure still fell short of the establishment which would emerge from an application of the Aberdeen formula.

The PRC agreed in late October that the necessary funds should be made available to finance a hospital nursing staff establishment of 1531 (which included the 25 in excess of available funds), and the committee noted that this decision would result in DF for Year 3 being pre-empted to the extent of £70,000 which would mean that other develop-
ments which had already received board approval could not be implemented.

This incident caused a split in the AEG, with three against keeping the establishment level at the figure of 1531, and one in favour. Because a consensus was not possible, the PRC, as mentioned, had to decide between the two choices put forward by the CANO on the one hand, and the remaining three members of the AEG on the other. The Treasurer was particularly concerned at the way in which the decision had been taken in complete isolation, instead of being taken after a review of alternative developments which the board might prefer to fund, or even after a comparison with nursing ratios in other areas. In his opinion, had the decision in favour of nursing been reached after an examination of all possible developments on which resources could have been spent, then that would have been more logical (and akin to the process outlined in a rational model of decision-making, as described in Chapter 4). But this had not happened and the decision, the Treasurer felt, had been taken on illogical grounds and for emotional reasons; furthermore, it had been the first time his advice had been rejected. The PRC's decision was unanimous, in part, the Treasurer thought, because nursing aroused passions - there was a widespread feeling that nurses were important and that the NHS depended on them for its very survival. Consequently, they were regarded as the backbone of the service. The episode undoubtedly placed strains, themselves the outcome of a stagnant economic situation, on the consensus
management concept. The Treasurer claimed that whereas in a normal growth year the CAMO, for example, could have agreed to an increase in nursing staff and still have had access to funds for services under his management, now that nursing had received DF at the expense of all other services, the CAMO was under fire for 'selling out' to nurses. Speech therapy, physiotherapy, radiography and other services were all clamouring for increases in staff.

This concludes the description of the allocation of DF over a two-year period in Alpha and Beta. It is now time to stand back from the fray in an endeavour to make some sense of what went on in Alpha and Beta over the period observed.
Chapter 13

THE ALLOCATION PROCESS: AN ANALYSIS

The purpose of the present chapter is to present an analysis of the allocation process described in the last two chapters. The chapter begins with a discussion of the importance of DF, and proceeds to examine the constraints operating on decision-makers. As revealed in the descriptive chapters, decision-makers in Alpha and Beta operated inescapably within numerous constraints which helped to shape the decision-making environment. Later in the chapter, an attempt is made to isolate the coping strategies, or 'aids to calculation' (to borrow Wildavsky's term), adopted by decision-makers to enable them to make sense of their environment in situations of uncertainty.

13.1 Importance of DF

Preceding chapters have made frequent references, implicitly if not explicitly, to the importance of DF. It is appropriate here to expand upon these and try to provide an answer to the question: why is it that health boards place so much reliance each year on these funds?

The real importance of DF lies in the fact that they are the only guaranteed source of 'new' (ie uncommitted) money that a health board receives. The only alternative source of new money is to effect savings in the remainder of the budget which is already committed to existing services. In the words of one DA in Alpha, 'that's the only other way we can introduce anything new or even extend anything'. Another DA in Alpha maintained that DF were important because
many people regard them as the answer. But if we're doing our job we should be looking at services to divert funds that are not being used properly at present, that is, re-deploying resources within the service. I don't think we've spent enough time on this in the past. The cry has always been 'we need more' instead of standing back and asking if we are using what we've got properly.

In fact, as was illustrated in Chapter 12, it is extremely difficult to rationalise services by reallocating resources, however desirable this may be. The Secretary of Alpha argued that redistributing resources meant

stopping a service of some sort or other, or reducing a service. It can be done, but it's not easy; the room to switch existing monies isn't very great. The main medium for changing direction is through DF, or through some large project, say, a capital scheme with revenue consequences, which brings revenue money with it.

A related problem is that the speed with which a board can move in a new direction with its DF is hampered in part by the current emphasis on community care. The Secretary expressed it in the following way:

People accept that if you do have to change direction it is more towards community care and this, by its very nature, does not bring with it so many large-scale projects. Health centres are the only development in this category, but they don't offer the same chance of switching from hospital based to community based services. So DF are the main way of doing it. It's a small percentage but it can make a difference ... . The effect has to be cumulative rather than emerge in any one year. It is the only way you can move, unless you can shut down services and use the money for something else.

To emphasise his point, the Secretary explained that he was not too concerned about the development of clinical services 'because most of the developments, or a high proportion of them, come through building schemes. There are
individual appointments but a lot come through opening new hospitals'. In other words, when DF are in short supply, it is community services which suffer most (apart from new health centres). Hospital services can expand to some extent through centrally funded schemes (see below). The CAMO in Alpha asserted that DF were

the one opportunity you have for shifting the emphasis in the service. If you've got any obvious deficiencies, DF are really the only way in which you can help to put these right, or alternatively develop something new altogether which perhaps ought to be developed. I know that you can reduce services ... you can close wards and close hospitals, you can diminish services. That is fraught with tremendous difficulty. Virtually, DF are the only way in which you can force the service to develop in the way you think it ought to.

Although both Alpha and Beta, and the boards that responded to the questionnaire (see below), were all agreed on the significance of DF, the importance of, and reliance placed upon, these funds can, to some extent, be linked to the size of a board and to its catchment area for patients. For example, the CANO in Beta claimed that DF were vital, particularly in a small area such as ours where, financially, we have very little room to manoeuvre because of the size of our budget. We have been able to recruit staff so there's no 'slack' in the nursing budget and yet our ratios are low, particularly in hospitals X and Y ... which historically have taken patients from all over (this part) of Scotland and are much bigger than we (in this area) require. We've still got to staff them and any move towards improving psychiatric or MD services in this area depends totally on our development money. We can't start community services because we've got no money to engage community nurses. We can't take them from existing staff because the ratios are so low - dangerously low in the MD unit. So development monies are certainly vital to nursing. They are vital because we have so little slack.
Like other officers, the CANO agreed that there were other solutions to the problem of providing a better service than dependence on development money. But, at least until the onset of 'low growth', development monies were easier to come by than better bed occupancy, or more efficient use of staff time, and so on. Administrators, as they themselves freely admitted, relied upon continuing growth as a means of postponing awkward decisions which would have involved full use of their management skills, such as, for instance, monitoring the effective and efficient utilisation of existing resources, both financial and manpower, and taking corrective action as required.

Responses to the questionnaire corresponded closely with data obtained from Alpha and Beta. All ten boards found DF to be indispensable for, as one board replied, 'medical and dental techniques do not stand still'. Several boards identified limitless demands on the service as being a primary reason for DF. One board noted that 'the demands of the public for extensions and improvements of health care and the abilities of the health profession to provide it are limitless'. Another replied:

the continuing demand for new and more sophisticated services to meet demands and to keep up with advances in medicine and care can only be met by development resources, either new and additional, or, more rarely, arising from reductions in services and/or their costs. The demand for higher standards is another significant factor.

Following on from this response, another board stated that in a service like the NHS, which has such technical developments, there must be a growth rate
each year to allow for improvements. It is easy to say that one should be looking for economies to provide for subsequent years' developments, but advances in medicine are always in front of the withdrawal of any particular activity.

As these last two responses show, and several other boards commented along similar lines, it was difficult to provide funds for improvements and/or expansions by making savings on existing resources. On the other hand, one board revealed that while it was very difficult to divert monies from an existing or established case, 'nonetheless it is not a bad thing for the growth rate of development to be strictly controlled otherwise a lot of money could be wasted'.

A final observation is that the importance of DF was directly related to general views about planning that exist in the NHS. Towell,\(^{(2)}\) for example, claims that planning 'is still tending to be seen as mainly concerned with ordering priorities for the use of any extra resources made available' (emphasis added) rather than as a means of redeploying existing resources or altering priorities within these.

'More of the Same' or New Directions?

No one, then, disputes the importance of DF for the provision, by health boards, of services where the margin for manoeuvre is a narrow one. But there is a problem when it comes to deciding how the funds should be used. Essentially, two options confront decision-makers: either DF can be used to plug gaps in existing services (ie improvements and/or expansions), or they can be used to shift the
direction in which a board is moving (eg a shift from institutional to community care). Occasionally it is possible to decide upon a mixture of the two (see below), but, as will be explained, it is normally obligatory to choose between these options - it is rarely possible to attempt to do both at once and, in the long term, implementation of one strategy prohibits taking, or makes it extremely difficult to take, action on the other. This dilemma faced consensus teams at area and district levels constantly, but never more so than during the period of activity over the allocation of DF.

Officers were well aware of the conflicting demands which, in some way, had to be reconciled. Nine out of the ten boards which responded to the question about whether they ever experienced conflict between expanding/improving existing services, and moving in a new direction, replied that they did experience conflict. The necessary choices were made more difficult because of the limited DF available. The CAMO in Alpha commented on the dilemma facing officers:

> When there are so many deficiencies, you tend to have to patch and really do what seems to be the most urgent in whatever fields there is pressure, rather than consciously neglect to do something. DF are spread over pretty thinly and anything terribly major can't be done.

Despite this short-term approach to DF, decision-makers tried not to lose sight of mid- and long-term developments they would like to see come to fruition. Yet, focusing on the short-term could act to preclude the realisation of longer term aims. As an officer wrote in reply to a
question contained in the questionnaire, the choice was to 'upgrade or improve a building or build anew, to expand a service in one city hospital or to allow another to open up in the same field'. The pressures operating on decision-makers were such that they were forced into a reactive posture as opposed to an anticipatory one. A DNO in Beta maintained that the allocation of DF in practice amounted to 'reacting to events', and a DA in the same board argued that there was 'no rational, objective basis for allocating DF and determining top priorities out of several mutually competing ones. A great deal depends on the persuasiveness of the case put forward'. A DFO in Alpha echoed these comments. 'In the past, before the DEG, I always felt that the person who shouted loudest got it (ie a share of DF). It wasn't always based on pure need or priority but because that person waved the shroud better than somebody else'.

In deciding allocations on the basis of either improvements/expansions and/or providing a new service, many considerations have to be taken into account by those allocating DF. For example, in one of the boards which responded to the questionnaire, a choice had to be made in regard to the development of a renal dialysis service. Public support for the project led to a kidney machine being purchased from funds raised locally which have, to date, supported its operation until the health board can take it over. Without this support, the board would have been compelled to defer introduction of home dialysis on the basis that funds
available should be used for the greatest good of the whole community rather than on a project benefiting only a few, however commendable. An awkward choice of a similar kind faced another board. This concerned the need to close, or redistribute, a service such as a small maternity unit, which was grossly underused, with an adequate alternative in a neighbouring town.

Sometimes, too, the sequence of events complicated matters. For example, as the Secretary of Alpha pointed out, requests for staff might start off as developments but end up as absolute necessities.

The problem is that by the time one considers these requests, the additional member of staff that has been requested to cope with the existing work load is not a development as such because the work load has increased so much that we’re entitled to have a consultant (or whatever) almost as of right. A large number of requests reflect existing increases in work load. They are not new developments, but are a response to work loads over which there is sometimes no control. One is caught up in the momentum of the thing. It’s all very well to say that the situation should never have been allowed to reach this stage, or that the board’s hands are tied and that it was forced into a corner. If patients come forward they have to be treated. This is why I want to build up the community side. It’s less expensive and is the best economic bet. It’s the only way to throttle off the demand before it reaches the hospital. Thereafter, most of the additional medical posts can usually be justified in terms of existing work loads. This is the way it works: two consultants begin; after one year, they wonder why things are so hectic, look up the figures, see they’re treating so many more patients, and put in a request for a third consultant. At this stage there’s not too much you can do about it.

The dilemma is that by using DF to increase staff establishments (ie 'more of the same'), resources are being committed which could have been put to other, perhaps more
effective, uses. (3) If the trend is to reinforce existing patterns of care through additional appointments, then altering the status quo becomes progressively more difficult. The dilemma does not pass unacknowledged. As the Secretary in Alpha put it, 'what does one say to a consultant? Does one say, 'as soon as you're doing more work than you ought to be doing, stop'? What does one mean by stop? If patients present themselves they've got to be seen'. The CAMO in Alpha also admitted to the existence of this problem, but added: 'sometimes it's resolved for you in that you just can't continue to expand the existing service because of lack of facilities. It's not simply a matter of getting more staff'.

At most, allocations of DF reflected a compromise between, on the one hand, simply plugging gaps in existing services and, on the other hand, initiating new services where possible. Incompatible elements within these two allocation strategies gave rise to tension. As the Treasurer in Alpha commented in regard to the board's DF, 'at the present time one is reacting to pressure points as well as working to a plan. We were trying (in our allocations of DF) to bolster the domiciliary services and we were trying to plug gaps'. Quite often, however, there was no choice open to decision-makers, and nor was it possible to arrange a compromise. Pressures arising from existing services presented officers with little or no alternative but to plough more funds into them to relieve the pressure. The CANO in Beta stressed that allocations of DF were a response to requests which amounted to
a 'shopping-list' of deficiencies and pressure points. We don't have a long-term goal or direction in which we're going. Pressures are on at this very moment. I don't think that's right, I think it's inevitable. There has been a tendency to say, 'well we're waiting for the programme planning groups and the Scottish Health Service Planning Council to come up with the answers'. That worries me a bit for a variety of reasons. They may come up with the answers we don't want or haven't had. Far more important is the fact that they are not going to come up with anything very quickly. We really should be planning over the next decade in broad, general terms. But then the pressure to do that isn't there because all our development monies are needed for first-aid or are committed to various projects already in existence.

An additional problem, revealed in Chapters 11 and 12, was that DF might be allocated to a mix of improvements and new developments but that, at the last minute, plans were thwarted by the flare-up of a crisis, such as occurred in both Alpha and Beta over nursing staff establishments. Attention to crises of this type required switching DF from proposed developments. A DA in Alpha expressed the dilemma facing administrators vis-à-vis short-term pressures on the one hand, and long-term strategy on the other, in the following terms:

You've got to look at the immediate need. For example, if I'm overweight I go to the doctor; he says in the long-term I should lose weight but I also need my appendix out. Obviously the immediate thing that requires attention is the latter but the long-term view must be kept in mind. Where possible, resources must go towards achieving the long-term goal. But if a crisis arises or the service is in danger of deteriorating, then resources must be diverted to that.

Most of the allocations cited in the last two chapters over the two-year period observed were a response to pressure points arising from existing services. Moreover, as the
remarks cited above show, officers were quite certain about the need to attend to immediate pressures but far less clear about what long-term strategy they should be following, if any, or, indeed, how far this should override short-term considerations.

Spread Thinly or Allocate in a Lump?

Apart from the problem of using DF either to finance improvements and/or expansions, or to start new services, there was a further tension point, which had its origins in the strategy chosen to allocate funds. There were two strategies, both of which cut across the improvements/expansions or new services dichotomy: (1) the strategy of spreading DF thinly in order to give something to everyone (fair shares); (2) the opposite strategy of channelling the bulk of DF to a particular development (priority-setting). The priority-setting strategy could refer either to allocation decisions taken to bolster the status quo, or to decisions to start new services (which usually required a substantial injection of funds). The fair shares strategy, on the other hand, was confined to expansions and/or improvements to existing services ('more of the same'). Often, when lump sums were allocated to developments in existing services, these decisions were not so much the outcome of priority-setting as such (ie in the sense of officers reaching a deliberate decision when faced with a genuine choice), but more usually the outcome of a quick response to sudden crises where officers could see no alternative but to bring these under immediate control (see further
As the descriptive sections in preceding chapters have shown, both Alpha and Beta tended to pursue the fair shares strategy, even if they did so rather reluctantly. The CAMO in Beta explained that 'at this stage we've taken the easy option by spreading (DF) around, in the absence of strong reports which would indicate that we were misdirecting funds'. The Secretary elaborated on these views.

In the past, everyone has tended to parcel out amounts to the A priorities. The aim has been to meet all the As, with the result that everyone got something and was reasonably happy. I've always been well aware that the role of the ABG to the board was to say 'we've failed in this channelling out of development money as a percentage to every department each year. The practice should cease'. The only way to improve the service is to channel the whole of our monies into a particular area which is so obviously under-financed that the only way to sustain it is by doing this. There should be less and less of little bits of money spent on a clerkess here, two nurses there, and an engineer somewhere.

But the Secretary appreciated only too well the obstacles lying in the path of such a switch in strategy. The problem remained,

what do you do when faced with requests for development monies largely for additional staff which came in this smallish board to just under £1 million last year? There are so many understaffed areas and so many which should be strengthened. Is there something to be said for just trying to improve a little bit here and there?

A DA in Beta made similar remarks.

We have tended simply to hand money round in small amounts to keep people happy. For example, if six porters are requested funds will be allocated for one; if three physiotherapists are requested, funds will be set aside for half (ie part-time), and so on. It might be better if we put all available funds into
one area of need. The difficulty is deciding what is a priority over and above all others.

This practice was not unique to Alpha or Beta. One health board, replying to the questionnaire, conceded that 'there certainly is a tendency to try, when the money available is small, to give a bite of the cherry to a number of categories thus spreading the money out rather thinly, when it might be advisable to give the bulk to one area'. There were, however, exceptions. Another board which responded to the questionnaire replied that it had decided that year to put money into the development in one district of psycho-geriatric and geriatric services 'rather than authorise single increases in establishments, eg a physiotherapist here, a speech therapist there'. However, the board also noted that although it had guidance in _The Way Ahead_ about geriatric medicine, psychiatry and community care, 'we have a conflict with the demands of the acute service'.

As noted in Chapter 11, district 'Y's' (Beta) priorities in Year 1 lay in nursing. The DFO explained why:

> we used quite a bit of our DF on nursing salaries because the DNO convinced us (ie the DEG) that we were rather under-staffed in the community in certain areas ... . We tended to lean over backwards a bit to show (the community) that we weren't favouring the hospital side.

The DNO in district 'Y' believed that DF were very important for plugging gaps.

> There is always a problem as to whether one should allocate resources by giving a lot to one particular activity, or spreading resources round everybody in small amounts. By adopting the latter approach one tends to see nothing in the way of improvements; with the former approach, one gets satisfaction from detecting
real improvements. This was the case with the community - nurses were writing to thank me for obtaining so much money for them.

The DA in the same district said that allocating DF was an arbitrary procedure and that there would be a 'compromise solution between allocating all funds to one service, and giving a little piece to various people which would satisfy the four disciplines (ie medicine, nursing, finance and administration)'. The DA added that 'putting all the funds into one sector might be of little use in any case since it might still be wide of the mark and be ineffective'. This is not to imply that the DA was making out a case for saying that it was more rational to act in this way but, as he proceeded to argue, 'this would seem to be more effective in that people are prepared to accept a little bit of the cake. But I don't think it's good management. This is where I'm in a bit of a dilemma'.

Although several officers in Alpha and Beta expressed their preferred allocation strategy of concentrating available DF in a particular area (eg community nursing), the decision to act in this way was sometimes forced upon them, rather than arrived at through choice after discussion (that is to say, it was not an example of priority-setting as such, since decision-makers were faced with no alternative). Over-spending on the nursing budget in both boards required the bulk of DF for two of the districts to be channelled into nursing, despite the fact that the original intention had been to allocate available monies according to a fair shares strategy.
There were other pressures on officers which made it difficult for them to allocate resources to start new developments, as distinct from expanding existing ones. For example, in Beta, district 'Y' requested a health visitor for a new contact tracer service, the request having arisen after publication of the Gilloran report on sexually transmitted diseases. At first the AEG approved the development, but later changed its mind when the CANO discovered that some requests for existing services involving additional nursing staff had not been met. It was not considered to be an opportune time to establish a new service after all.

How DF are allocated, and to what purposes, depends to some extent on the planning capabilities of health boards. The specialist expertise in Alpha and Beta lay in the field of physical planning; service planning was the responsibility of the two AEGs (programme planning groups were also involved in planning but on a long-term basis), but administrators at this level are not trained planners and lack the necessary skills. Their experience and expertise derive from the day-to-day administration of the NHS, even at area level where a more strategic outlook is supposed to prevail.

Planning necessitates choices which reflect a commitment, however flexible the approach adopted, to certain broad aims. The CANO in Beta expanded on this. In his view, planning

will probably mean that we have to decide that
geriatric care, or care of the mentally ill, or whatever has priority for that particular year, and they get the bulk, or all, of the available resources and everybody else does not get very much. At present, I don't think we are indulging in long-term planning in the AEG. Although we tend to say that it's (ie the allocation process) based on real priorities, I think certainly once it gets into the broad category of nursing the tendency at the present time is for each little corner of nursing to get a bit. They get a bit mainly because they need a bit but I think we're simply bolstering up a service which is unsatisfactory - we're bolstering it up by another couple of nurses or something but we're not really tackling a particular area of care and providing the resources which will allow, for example, geriatrics to be looked after as well as they might be at home. We tend to fool ourselves at the moment if we think we really are financing priorities. They are priorities in the sense of low staffing ratios and so forth, but inevitably each bit of nursing gets a bit of money at the present time. We're not tackling any major programme.

A DFO in Alpha reiterated these views: 'Probably the approach up until now has been a bit piecemeal. Everybody's putting forward what they think are their own needs without looking at a particular plan'. Part of the problem identified by the CANO in Beta occurred because allocations of DF were approached in input oriented terms rather than in terms of output. 'We're not saying, for example, we'll institute a sensible programme of care for the mentally ill which would involve a nursing component'. Rather, resource allocation was looked at 'in terms of different heads of expenditure, additional staff numbers, and so on'. A Secretary of one Scottish health board wrote that (4)

the reorganisation of the service clearly presents an opportunity of adopting a more systematic approach to planning. There is little doubt that, in the past, planning has
been largely piecemeal in character and aimed primarily at increasing the supply of staff, buildings, etc.

All health authorities confront similar problems. For example, in England, Wessex Regional Health Authority initiated '(a search for a sounder base for allocating resources)'\(^{(5)}\). The review undertaken argued that evidence available to judge the relative priority of claims for new resources is limited. Most areas, it said, could advance claims for special consideration for one reason or another, whether it was a high proportion of elderly people in their population or whatever. There was a need, the review paper continued, to look for a better method of judging the relative level of resources available to particular populations and try to develop an allocation procedure which would lead towards greater equity. A similar exercise was mounted by the Area Team of Officers in Gloucestershire AHA. In a discussion paper,\(^{(6)}\) the team argued that there is no difficulty in setting out the objectives of the health service. The difficulties arise in deciding 'which objectives should receive proportionately increased resources, that is, the priorities, and the most effective means of achieving the chosen objectives'.

The last two chapters have provided sufficient evidence to show that the planning of services provided by health boards (certainly in the case of Alpha and Beta) tended to be confined to dealing with the annual financial increment to service spending (ie development funds). The great bulk of running costs of services continued much the same
from one year to the next. It was only the annual additional 'increment' that could be used in the short term to alter the character or distribution of the services. The 'new' money each year represented the real growth in NHS expenditure and was used to correct imbalances between services, and to satisfy pressing demands from staff. A similar conclusion was reached by Brown et al\(^7\) in their study of Humberside AHA. Planning was felt to be useful if the cash was there to meet the requirements (what the authors call the 'development syndrome'), but was of little use if no additional cash was available. In the latter case it was seen as an 'academic exercise'.

Incrementalism is frequently associated with processes of resource allocation and budgeting which follow the pattern outlined above.\(^8\) Incremental budgeting is concerned with seeking to finance facilities already available. Schultze\(^9\) argues, in a different context, that most of the individual budget decisions made each year are incremental in nature, and by incremental budgeting he means a system whereby budget reviews examine only those items for which increases over the prior year are requested. Unless a new programme is proposed, there is no examination of the basic programme structure or performance. In short, to use the jargon, there are no 'zero-base reviews' - the base for most reviews is the previous year's budget levels. Wildavsky\(^10\) has described a similar process on numerous occasions. For him, and for Schultze too, a non-incremental policy may be defined as one that departs
sharply from past practice, or one that requires a very large increase (or decrease) in the commitment of resources to a particular area. In resource allocation processes, the synoptic ideal is impossible to obtain in its pure form, although it is frequently held out as a goal to be approximated as nearly as possible. But, as the account of the development fund allocation process tried to show, actual budgetary decisions disclosed a somewhat different picture from the ideal (see also next section on constraints). Alpha and Beta, and other boards, to judge from their responses to the questionnaire, operated incrementally by restricting attention to small segments of a total problem, comparing a few alternative marginal departures from the existing situation and considering only what could be achieved with readily available resources, namely, DF. This strategy is akin to Braybrooke and Lindblom's 'successive limited comparisons'.

Claims on development funds, as illustrated in Chapters 11 and 12, emerged from above and from below. A major part of development revenue was allocated each year to meet the running costs of new capital schemes or government-sponsored developments, such as the operation of a family planning service. At local level, departmental heads within boards were invited each year to submit lists of requests from which the higher tiers could make choices. This 'begging for a slice' of available development money was the norm and it was rarely suggested (not, at any rate, in a meaningful way) that other policy options
existed, like expanding certain services by reducing others.\(^{(12)}\) This, very schematically, was how incremental funding operated in Alpha and Beta. The next section examines the very real constraints, both political and structural, which inhibited and hindered the introduction of different approaches to resource allocation decisions. These latter approaches may be seen as part of the attempt, which began in earnest with reorganisation and was, as has been noted, a fundamental theme of the 1974 reforms to attain the synoptic ideal.

To sum up the discussion so far, it was accepted by most health boards, and by those whose task it was to allocate resources, that DF were a vital source of revenue. Nevertheless, insufficient funds existed to satisfy all the requests for them, and competing demands had to be settled according to one of two strategies (within each strategy further sub-choices were necessary). The strategy most commonly adopted was one of fair shares, the aim being to keep as many people happy as possible while disappointing only a few. This strategy was closely linked with the practice of using DF to attend to existing services and to 'put out fires', rather than attempting to use the funds to shift the direction of the service by initiating new projects. Occasionally, elements of both strategies or practices might be pursued simultaneously (as they were to some extent in Alpha in the field of community care; see below, section 13.5). More often, one strategy or practice was selected at the expense of the other, and on most
occasions the choice was in favour of improvements and/or expansions of existing services. These two sets of tensions have been dealt with at length because they underlay the entire allocation process concerning DF and the decisions which emerged from it.

13.2 Constraints (1) External

Two main sets of external constraints operated to restrict decision-makers' freedom of manoeuvre. They were observed at: (a) the interface between health boards and local authorities responsible for personal social services; and (b) the interface between health boards and the SHHD.

Health Board/Local Authority Interface

Although integration has occurred between primary care, hospital care, and community care, personal social services remain under local authority control. But while health services and personal social services are administered by separate authorities, one appointed and the other elected, in reality there is much overlap between the two sets of services. Inevitably, therefore, policies pursued by one set of agencies can have an impact on the other, and while it has not been the purpose of the present research specifically to observe liaison arrangements between health boards and local authorities, aspects of this relationship (or lack of one) crept into the decision-making process over DF. In theory, close cooperation between the two sets of authorities ought not to be too difficult to achieve. According to official policy, if a health board wishes to ease pressures on the hospital service, one way to achieve
this is to expand community care services. Moreover, reorganisation of the NHS was, in part, intended to facilitate such a shift in health care priorities. Comments from administrators cited in the last two chapters indicated that they too saw the future development of the NHS as lying in this direction. Yet, there were few visible signs of close cooperation between health and local authorities in Alpha and Beta. Decisions taken independently by one authority could have repercussions on the policies being pursued by the other. For example, home helps are an important element in any policy shift from institution-based care to community care, but they come under local authority control. Cuts in local government expenditure had an adverse impact on the provision of home helps which made it considerably more difficult for health boards to speed up discharges from hospitals, particularly among geriatric patients requiring nothing more than a little support. In Chapter 12, Beta's decision to spend most of its available DF on the opening of an orthopaedic surgical unit was examined. It was also pointed out that in its review of orthopaedic surgery in the area, a working party set up by the board had concluded that the pressure on existing beds (which the new unit was intended to ease) was caused by geriatric patients clogging up beds owing to a lack of suitable alternative facilities either in the hospital sector or in the community. The view expressed in the report was that if this problem was solved, then the number of beds available for medical cases would probably be adequate. Yet one obstacle to solving the problem was the
inability of the board and the local authority to agree on a policy for the elderly. The working party ended its report with a plea for cooperation. It suggested that there was perhaps no aspect of the health service in which there was a closer interdependence between health services and local authorities than in the field of caring for the elderly. The great majority of elderly resided in the community but a substantial number were unable to continue living at home without some form of support. In the words of the report, 'the involvement of local authorities in the care of the elderly must influence the provisions which the health service requires to make'. Apart from home helps, there was 'a growing and urgent need' to increase the provision of local authority day centres. More facilities of this nature would relieve the need to provide inpatient accommodation.

It was not only the elderly who were in need of better community services, but those patients suffering from mental distress. In the case of Beta, there were two large hospitals for the mentally ill and the mentally handicapped, and, as was shown in the two previous chapters, their staffing needs, particularly in nursing, were, not to put too fine a point on it, voracious. Once again, however, action in this area depended on policies pursued by local authorities. The working party, in its review of services for the mentally ill, concluded that many of the wards were 'antiquated' and 'unsuitable'. It was noted that the bed complement was over and above the needs of the area but that the main factor which would ultimately affect
the requirement for beds was the scale of the provision of facilities in the community, among which were local authority day care centres. A similar situation prevailed over the provision of facilities for the mentally handicapped. The working party's report concluded that accommodation for patients who had reached the stage of being able to make a partial return to the community was inadequate. 'In this field, as in the psychiatric field, the question of the involvement of the local authority makes it difficult to assess exactly what provisions the health service should make on its own'. Since the hospital for mentally handicapped patients was 'grossly overcrowded', the aim, according to the report, should be to reduce the number of patients accommodated. But such a reduction in admissions could only be hoped for, in part, by an increase in the provision by the local authority of facilities such as day care centres. The alternative to this, or as an interim measure until these longer term changes began to take effect, was to increase substantially staff/patient ratios to improve immediately the level of care. This was the course followed in the allocation of DF. Had close cooperation existed between Alpha and Beta and their respective local authorities, it is reasonable to assume that this might have been reflected in different uses being found for at least a portion of DF at the disposal of both boards. It is not possible to be certain about this, but it is unlikely that there would have been the same pressures to boost staffing levels if other means were being pursued which would have alleviated the causes
of these pressures. However, faced with these pressures, and with no other options readily available, decision-makers had little choice but to accede to some of the demands for more staff.

Although the above examples have been drawn from Beta, where the problems were possibly more acute for historical reasons (e.g., the existence of two large hospitals in an area which did not strictly require hospitals of this size), Alpha experienced similar difficulties. Regardless of particular health boards, the key to shifting the burden of caring for long-stay patients from relatively expensive hospital care to the community has always been the social services. Yet, as preceding paragraphs have suggested, local authorities are no closer to the NHS than before re-organisation.

Although the importance of cooperation between health boards and local authorities was a dominant theme in the proposals for the reorganisation of the Scottish Health Service, as outlined in the 1971 White Paper, no specific bodies were established to pursue collaboration between health and local authorities along the lines of the JCCs (and also Joint Care Planning Teams) in England and Wales. This was partly a result of the different timescale for local government reform in Scotland which occurred a year later than in England, i.e., May 1975 rather than May 1974. However, changes are in the offing following the publication of the report of the second working party on relationships between health boards and local authorities(13) in August
The first working party was set up in October 1971 and their deliberations resulted in the issue, in July 1973, of circular HSR (73) C 26 on cooperation and liaison during the transitional period up to May 1975. The second working party was set up in late 1973 and its principal recommendation, which the Secretary of State has accepted, is that joint liaison committees (JLCs) should be set up between health boards and local authorities.

It is necessary to look at English experience in collaborative activities if an idea is to be gained of how the new liaison machinery may work in Scotland. Certainly, prior to the working party's report, the rather general guidance issued by the SHHD in its 1973 circular has achieved very little, if the experiences of Alpha and Beta are anything to judge by. In England, the general impression has been that JCCs have not achieved a great deal through joint planning as the pressure has been mainly on the local authorities to do more. This criticism may be applied with equal force to the existing informal Scottish arrangements, and perhaps also to the new JLCs. In the circumstances it is a natural outcome; social services are operating under constrained budgets, and local authorities often have different priorities (eg in education or housing) from those the NHS may wish them to adopt.

It was in recognition of these factors, which themselves had led to the unsatisfactory operation of JCCs in England, that joint planning and joint financing, on a modest scale, were introduced. As one observer has argued, (14)

The current emphasis on joint care planning
between health and local authorities, and the extra finance made available to encourage this, can reasonably be taken as evidence that the original concern with coterminous boundaries of these two authorities and the establishment of JCCs ... has even at Area level fallen rather short of what was intended.

The DHSS' reasoning is that:

the initiative of central government in promoting joint planning and joint finance over administrative boundaries that have not always been easy to cross at local level, is intended to complement the development of corporate planning within authorities.

It is also fairly certain that the DHSS' commitment to a joint approach to social policy stems from the Central Policy Review Staff's work in this area. In Scotland, there are as yet no plans to introduce joint finance arrangements. As mentioned in Chapter 10, this is illustrative of the general difference in approach to health planning between England and Scotland, with greater central intervention a feature of the former.

Health Board/SHHD Interface

In Chapter 10, it was argued that despite considerable freedom to allocate resources, health boards were, at the same time, subject to certain national policy decisions (the two examples encountered in Year 2, and described in Chapter 12, were family planning and junior doctors' pay), which it was their duty to observe and implement. In times of growth, as pointed out in Chapter 12, this pre-emption of funds by national decisions was disguised through additional monies coming from the SHHD; but during periods of low-growth, as in Year 2, boards were expected to find the revenue for national policies from within their own allocations. This
outcome, therefore, tended to confirm the view of many officers that during periods of resource scarcity the SHHD intervened more readily in the affairs of health boards although this intervention did not mark a change of policy by the Department. The Treasurer in Beta pointed out that national decisions assume greater significance during a time when development monies are very small, and create difficulty. In a normal period (ie with a growth rate of around 3½%), it's fair to say that these decisions would not take up an undue proportion of funds available. The area of discretion would be left largely with the individual health board to determine its priorities within the DF available.

Most officials within the SHHD agreed that the tight resource situation had led to greater Departmental involvement in health board affairs which, in turn, had acted to curtail board's autonomy. Prior to the economic problems, the SHHD funded additional major capital developments by allocating sums of money over-and-above the basic allocation of DF. Because major schemes brought money with them for running costs it was, as Alpha's Secretary said, an 'easy way of developing the service (and) of financing additional staff'. But, according to an Assistant Secretary in the Finance Division of the Scottish Office, health boards were in the habit of always arguing for new developments. The SHHD was never informed of schemes that were being run-down; consequently, a 3% growth rate was, in fact, nearer 4½%. This enabled health boards to preserve the 3% or so for their own developments while for other schemes, the Department was expected to allocate additional sums. Consequently, the Department was intent on
reviewing the priority of major capital schemes. The results of this review were noted in *The Way Ahead*. In particular, boards were warned that if the running costs of new buildings were greater than those of the buildings they replaced, improvements in other sectors of the service would have to be foregone.

The climate in which administrators within health boards operated was affected by Departmental action, even if this action exerted an indirect influence on the decisions boards took, rather than a direct influence. For example, as noted in Chapter 12, in Year 2 boards were requested by the SHHD to give priority to schemes with no running-cost implications. However, this rather contradicted the Department's attempt to shift the balance of health care provision towards the deprived sectors and towards community care services. For priority groups (the elderly, children, the mentally ill, and the mentally handicapped), community services were particularly essential but improvement in these required, above all, increasing staff establishments (unless, that is, local authorities were to improve social services in the community for members of these priority groups: see above), which ran counter to the SHHD's stated intention of favouring schemes with no running costs. The fulfilment of this requirement inevitably reinforced the institutional bias in health care provision which rendered further improvement in community care more difficult. It was in this contradictory, stop-go environment that administrators had to make decisions which, cumulatively, had a considerable
effect on the future development of services under their control. The Secretary of Beta maintained that during the period since reorganisation all the board could do was react to events.

Forward planning is very difficult. We need clear-cut advice. (It's a) stop-go situation at present and planning is impossible. Our capital programme is cut, then we're told money is available to help ease the unemployment situation. But we have to choose projects with no running-cost implications, which means we are giving priority to schemes which don't really warrant it. How can you plan on this basis?

However, as indicated in Chapter 10, the relationship between the SHHD and health boards is not akin to a superior-subordinate one (unlike, for example, the line relationship between areas and districts). It is in many ways more complex, a consequence primarily of its ambivalence. Popular mythology suggests that administrators in health boards are incapable of exercising any autonomy they may possess for fear of upsetting the Department. This is too simplistic a view of the relationship. Not all board officers suspected the Department of being intent on interfering in, or on gaining control over, their affairs. Some, in fact, claimed that a degree of centralisation was necessary and even welcomed it if it was in the form of support rather than in the form of crude 'Big Brother' authoritarianism (which it rarely, if ever, was). In an effort to analyse the relationship, the Secretary of Alpha commented:

the Department has always been very reluctant to instruct a hospital or health board - this is not their way of doing things. It's always guidance. The Department doesn't want to give instructions or be drawn into a situation where it would have
to do so. It does occasionally, if someone refuses to do something which is national policy but I'd be surprised if this has happened more than half a dozen times since 1948. It could crop up over the closure of a hospital. The Department allows us a lot of autonomy. One thing we've got to recognise is that the Department is now dealing with fifteen health boards as opposed to five RHBs. The boards are smaller units now and the resources available to each of these units is going to be less than was available to RHBs in certain fields and that by itself may lead to a degree of centralisation. The Department can trust five big RHBs but because fifteen health boards are smaller you can't allow all fifteen to go their separate ways, therefore you've got to draw something back to the centre. Smaller units allow greater central control because, for one thing, it is easier for the Department to divide and rule. There is more opportunity for the Department to drive a wedge between health boards. Each RHB was pretty powerful by itself and five RHBs united against the Department was a lot for the latter to take on. With fifteen units the chances of getting a collective view are much less.

The Secretary believed that this had been an aim of the SHHD from the start.

We've got to make better use of resources and, to this end, more centralised control is a good thing, particularly when a health board is facing opposition from its staff. A better use of resources means a reallocation of existing resources and that means a greater degree of centralisation. The younger generation of administrators don't mind greater centralisation. A degree of centralisation would be a good thing; it would help equalise inequalities. In one's own area one is likely to come up against vested interests of one sort or another and central backing in these situations would be useful.

More often, however, board officers were exasperated by the vagueness, or sheer impracticability, of much of the advice emanating from the SHHD and this did much to reduce the Department's influence at the local level. Rather than being a potent force, or fulfilling a supportive role, the Department was looked upon with much less seriousness or
respect. Moreover, on occasion, officers were rather suspicious of the real motives behind a particular Departmental move or circular. For example, the CAMO in Alpha believed that the SHHD issued much desirable information more in an effort to 'cover' itself in the event of any trouble rather than because if felt the information should, or could, be acted on by health boards. He cited the example of fire precautions, and explained that all the board's DF could have been swallowed up by this single development and still some requirements would have remained unmet. In a rational, ideal world such information was necessary, but given the nature of existing realities it was not possible to do everything. Much information, therefore, was not acted on. Circulars dealing with such matters are often unrealistic in their demands simply because the SHHD takes a detached view of the matter in hand. On fire precautions, for example, to have avoided criticism would have involved investigating each hospital and clinic to arrive at exactly what was necessary in that particular area.

In certain areas, and for certain lengths of time, the SHHD maintains a firm grip on the policies pursued by boards. For example, after a public outcry, following reorganisation, about 'excessive' bureaucracy in the NHS, the SHHD declared a halt on recruitment of administrative and clerical staff. For certain new posts, boards had to seek SHHD approval before making appointments if these exceeded the figures applicable on 31 January 1976. (17) With the publication of the memorandum on priorities in April 1976,
health boards were expected to operate within the guidelines laid down. As mentioned in Chapter 12, the memorandum marked a departure for the SHHD in two respects: (1) it was the first document to deal with the NHS in a comprehensive way; and (2) the Department wanted to receive comments on the memorandum from boards, which was the first occasion on which feedback had been requested. Circulars, for instance, were not followed up in order to discover how boards had reacted to them. Apart from the memorandum, there were other indications that the Department, since reorganisation, seemed to be taking a keen interest in the activities of health boards. One of these was a request by the Department for boards to submit interim assessments of need in their areas to enable the SHHD to build up profiles of service provision in each board. Another indication was the creation of two working parties centrally to examine resource-allocation and priorities. Their establishment was prompted by the squeeze on resources which served as a catalyst for further central intervention. The working party on resource-allocation reported in August 1977;\(^{18}\) that on priorities issued an interim report in February 1977.\(^{19}\) This series of events, beginning with the publication of the priorities memorandum, represented the centre's reaction to pressures of a political nature. Neither separately nor collectively, however, do they form a master plan of the NHS to which the SHHD is beholden, nor is there such a plan in existence.

Apart from issuing advice and guidance, the Department imposes certain limits on health boards through the laying
down of conditions of service, salaries, and staffing norms. All of these are decided upon in conjunction with the appropriate professional bodies who are largely responsible for negotiating national agreements with their inevitable centralising tendencies. Health boards are free to operate within these limits, and in the specific area of DF, as mentioned in Chapter 10, boards are able to allocate these as they wish. Over capital spending, the SHHD has more control, although the distinction between capital and revenue is somewhat artificial and it is not always easy to keep the two separate. As the description of the allocation process in Year 2 made clear, capital and revenue spending are related. In major capital schemes, for example, the running costs (ie revenue) are normally included in the allocation from the central department. According to Beta's Treasurer:

if you find your place in the major programme you then get the identifiable additional running costs guaranteed. This would release DF for the community services, if you were lucky enough to have major schemes for the hospital service within the centrally-financed programme. If you were not involved in this programme then DF might be needed to finance the running costs of schemes within the board's own ordinary capital programme.

What this means is that schemes in the major programme have their running costs protected while other schemes, including many community ones, have to find their way through the ordinary programme and share in the competition for DF. Moreover, at a time of resource constraints, those capital schemes which either effect savings or have minimal running costs will be favoured over those which generate additional
running costs even if, from a board's point of view, a scheme coming into this last category has top priority. Therefore, this could mean a channelling of capital funds towards certain types of activity only. As comments made earlier in this chapter (and in Chapter 12) by officers suggested, this was precisely what was beginning to happen.

The relationship between health boards and the SHHD, on the evidence obtained from Alpha and Beta and from general observation, is a somewhat confused, ambivalent, even paradoxical, one. While it would be incorrect to conclude that a high degree of centralisation exists which totally excludes local autonomy, there are indications of a shift, with greater interest by the centre in health priorities and policy-making becoming a feature of the relationship. This has emerged with reorganisation and as a response to resource constraints and related political pressures. In many ways, the relationship combines a mixture of centralising and decentralising tendencies, which accounts for the paradoxical situation whereby health board officers and civil servants make contradictory statements which are, in a sense, both correct. For example, while many officers at board level, and in the SHHD, deny that the centre's influence is increasing, it is accepted by some that the existence of fifteen boards does facilitate intervention by the Department; a counter-argument reaches the opposite conclusion, namely, that it is much more difficult for the Department to throw its weight around when there are fifteen authorities to confront. To complicate matters further,
officers may resent inroads into their allocations of DF because of national policy decisions, while, at the same time, welcoming an increase in central influence over priorities both as a means of giving boards a lead and a clear direction, and as support for them when faced with strong opposition from the professions over, say, hospital closures.

The relationship, then, is complex and has many conflicting strands running through it. It is possible to detect in the ambivalence the emergence of a new kind of relationship between the centre and the periphery which encompasses these conflicting strands. In this context, Schon's work on organisations and 'connected decentralisation', where there is a shift from vertical relationships to collateral ones, is relevant. (20) Traditionally, in the NHS, the SHHD has either kept right out of the affairs of health boards, or has come down heavily on 'recalcitrant' authorities. But the relationship is undergoing a transformation and an attempt is underway to establish a dialogue between centre and periphery. Negotiating and feedback strategies are key features of the 'new centralisation' and the 'new decentralisation'. Both the memorandum on priorities, and the assessment of need profiles, were attempts by the Department to enter into a dialogue with health boards on future health policy and health needs; they were not initiatives designed to dictate to boards, although it was easy to, and many did, misconstrue the motives behind them. At the same time as the centre becomes less authoritarian but
more pervasive, the periphery becomes less submissive but more cooperative. This was the thrust of the Secretary's remarks quoted above when he suggested that 'a degree of centralisation' would be beneficial, provided it was supportive. Many of the complaints of central intrusion into health board affairs revolve round the type of intervention, particularly when advice is given which bears little relation to the realities of life at board level. The new relationship between centre and periphery, which is beginning to evolve, is intended to overcome these difficulties. It must be emphasised, however, that pervasive central involvement in health board affairs should not be equated with central control over what boards do. In any relationship there has to be give-and-take and when it comes to DF, for example, boards are not obliged to allocate them in particular ways. This is not to suggest that boards are wholly free in their decision-making activities in regard to these funds; there are many internal constraints (see below) operating which, if anything, can be more restricting than any central intervention. Health board autonomy from central control is not meant to imply autonomy from other influences operating internally at board level. While potentially there may be autonomy, in reality all is not as it seems.

13.3 Constraints (2) Internal
The environment within which officers in Alpha and Beta operated imposed numerous constraints on their freedom of action. Eight, in particular, played a crucial role in determining the allocations of DF which were described in
the last two chapters.

**Existing Services**

Health boards, in this instance Alpha and Beta, were stuck with the services inherited from the past - there is never a 'clean slate'. The allocations of DF were not concerned solely, or even primarily, with services starting from scratch; once services were established, a board was committed to maintaining them particularly when they rapidly gathered momentum and were seen as being indispensable.

Mention was made in Chapter 12 of two large hospitals in Beta for those suffering from mental disorders. The staffing demands, particularly for nurses, of these institutions seemed insatiable, and placed a severe strain on Beta's DF for the district in question. Indeed, as noted in Chapter 11, staffing problems at these two institutions led to overspending on the nursing budget. As the district's DA commented in relation to requests for funds, 'the DNO could make a very strong case for all DF going to nurses'. Faced with these pressures (and Alpha, as the description of the allocation process in Years 1 and 2 showed, had its share of these), officers could choose between immediate, though temporary, relief, or longer-term solutions to these problems. Quite understandably, the preference, as the allocation decisions indicated, was to provide immediate relief to ease pressure points. This meant forever tinkering with staffing ratios, adding to them in small increments as funds and staff became available, rather than, for example, taking a longer-term view and allocating funds to community
services which, eventually, might have lessened the demands on hospitals, including the two located in Beta, which, in time, would have removed the ever-increasing pressures on staff. But, as the Secretary of Alpha pointed out, while one tried to do a bit of both, that is, attend to existing pressure points as well as begin to shift the emphasis of health care away from the hospital service, it was far from simple in practice because as demands built up on, for example, consultants, it was not possible to stop patients from being seen. The episode over the orthopaedic surgical unit in Beta in Year 2 is a good example of this tension at work.

Other examples could be cited to illustrate the seductive pull of existing services, although it is hard to pick out particular instances when the entire allocation process was weighted in favour of perpetuating the status quo, ie 'more of the same'. Laboratory services in Alpha provide a further example; they were a rapid growth sector, and concern was expressed at the apparent inability of anyone to control their momentum. Each year requests were put up for further staff, and each year a further sum of development money was allocated to the services.

Inevitably, then, existing services wielded a powerful, if not a decisive, influence over allocations of DF. But in a setting where 'priorities by decibels' represented almost the only viable allocation strategy pursued by both boards, it was from existing services where the loudest voices and the noise inevitably came. New departures could not com-
pete, or, at any rate, found it extremely difficult to do so.

**Time Lag**

This constraint was evident in both boards, and referred to developments being funded in the present which had been inherited from the past, usually from the former health authorities (ie before reorganisation). In short, DF, in some cases, were already committed before they were even allocated or spent. There was, for example, the new maternity unit in Beta which received funding although it went against the priority recommendations in *The way Ahead*. It was, in the jargon, 'an ongoing commitment'. Yet, in the new economic situation, when maternity generally was being cut back to release resources for other purposes, perhaps the maternity unit ought to have undergone a change of use to cope with some priority area such as the elderly, a major area of need in Beta (as well as elsewhere). But, according to the district officers, the unit could not be altered in any way because the board was too deeply committed to it. In this way, the time lag constraint hindered the redeployment of resources and narrowed down the options open to decision-makers when allocating DF.

Other examples of time lag concerned the nurse staffing crises in Alpha and Beta over the two years observed. The crises had their origins in the days before reorganisation, when BoMs gave nursing officers a free hand to acquire staff when possible. Not surprisingly, such a permissive act led to overspending on the nursing budgets in both boards which
prevented other developments from going ahead since substantial amounts of DF had to be channelled to those districts in which overspending had occurred to enable financial order to be restored.

Real Time
This was an obvious constraint which affects decision-makers in any organisation. Nevertheless, it remained a crucial one, since a fairly rigid timetable was adhered to in allocating DF, certainly in Year 1. Generally, the quicker decisions were taken, the sooner funds could be spent and staff appointed, and the less chance there was of funds remaining unspent at the close of the financial year and then being hurriedly spent on items of dubious priority. But a tight timetable had disadvantages. It reduced the time available to administrators, particularly at district level, to prepare detailed cases supporting each submission for DF. This meant that many allocation decisions were taken on the basis of crude information since they had relied for their success on subjective criteria of their necessity or priority. It was mentioned in Chapter 11 how both the DAs in Alpha had complained in their memos, which had accompanied the development lists, that they had had insufficient time to consider the requests as thoroughly as they would have wished, and that they had not been able to put them in exactly the priority order that they would have preferred.

The real time constraint also highlighted some of the tensions apparent in the relationship between areas and
districts. Since district officers usually possessed more detailed information about staffing needs, and so on, than their area counterparts, most of the detailed allocation decisions occurred at district level. But, as the discussion of the area-district relationship in Chapter 8 showed, as well as the description of allocations in Year 1 in Chapter 11, this state of affairs gave rise to friction between the two tiers, a result, primarily, of the fact that the area was in charge of broad planning and policy-making while not being particularly well-placed to argue the merits, or otherwise, of particular developments. This structural problem was exacerbated by the time dimension which served to prevent area officers from briefing themselves adequately on detail. To some extent, the same problem, but in a much diminished form, occurred between districts and sectors. It is worth pointing out at this stage that the real time constraint permeated the remaining constraints considered below.

Information
This acted as a constraint in two ways: either there was (1) a surfeit of information which was just not being made use of (for reasons of information overload, or poor dissemination), or (2) a shortage of particular kinds of information. In other words, the constraint comprised a combination of political and technical factors. By political is meant the ability of individuals or groups either to withhold potentially useful information, or the reluctance to make use of data in a way that might threaten particular interests. On occasion, information was available, or
could quickly be assembled, but was ignored, or not gathered, because of the time required to put it into an appropriate form. A political problem was the selected distribution of particular types of information to those who stood to lose out if action was taken based on what the data revealed, while those who might have been in a position to act upon it were unable to gain access. A prime example of this practice was cited in Chapter 12; it concerned bed occupancy rates - information about these was always made available to consultants but not always to officers. This was an example of the impact of clinical autonomy on decision-making and how it could render officers helpless. Of course, even if officers had been in possession of all the data concerning bed occupancy rates there would have been many obstacles, mainly of a political nature, encountered in trying to act upon what might have been revealed by the data. Nevertheless, the technical problems involved in assembling data, and the political problems involved in gaining access to available data and in persuading professionals to act on it, resulted in greater weight being attached to the persuasiveness of a particular officer in putting a case for a development. For example, at one DEG meeting in Beta, a heavier weighting was given to the DNO's case because her cri de coeur seemed to be the loudest at that time and there was no time to establish the known facts and figures, although officers were familiar with the broad background to the request. This relatively small example could be multiplied ad nauseam. A further problem, which is elaborated below under priority-setting, was that
there were limits to the usefulness of information in assisting decision-makers when deficiencies of equal need had been identified among several sectors. Masses of statistics are routinely collected in the NHS but they do not assist in making the fundamental decision of whether to establish or expand one service rather than another.

In deciding allocations, the main types of information used were: staff/patient ratios, staffing numbers (reference was frequently made to a document published annually, *Scottish Hospital Costs* (SHC), for comparisons with other boards; if a particular board was unable to attain the ideal staffing norm, as invariably was the case since staffing norms were usually considered to be unrealistic in terms of practical attainment, then SHC acted as a guide as to how a particular board was faring by allowing comparisons to be made with comparable hospitals, etc, in other boards), workloads, waiting-lists, and bed occupancy rates. These types of data tend to be rather crude and do not necessarily provide reliable indicators of need, possibly reflecting instead other factors like, for example, inefficient staff output. However, in the absence of agreed measures of output, the data available at present are all that decision-makers have to assist them in taking decisions on DF. Moreover, as has already been mentioned, not all information may be useful in a real life setting. Staffing norms in particular are widely believed to be unrealistic and virtually unattainable within existing growth rates, yet they provide various professional groups with powerful bargaining weapons. Klein(22) has argued that the derivation
of establishment figures is often obscure and is the result of pressures and counter-pressures rather than of rational planning. It is, in any case, extremely difficult to arrive at objective staffing norms since there are in practice wide variations between hospitals, even those in the same category. As the CANO in Alpha explained:

Even if you have your norm for staff there's always something changing on the ward. A new consultant comes and he has different ideas from his predecessor - that alters your ward pattern completely. You may have a quicker turnover of patients, or your patients are kept in bed longer. Furthermore, the consultant may do more complicated operations requiring more specialised nurses. Every time there's a change you need to look at your staffing position again. A new consultant always brings work with him. Just now as soon as you have your staff establishment it's more or less out-of-date right away unless you keep reassessing it from time to time and changing each ward.

The CANO went on to point out that it was not often that there was a reduction in the workload for nurses; usually it was the other way round. 'We are aware that when a consultant comes this will mean extra staff and we're able to put forward a case'. It is a cyclical problem: a consultant is appointed because of an increasing workload; he then proceeds to help increase the workload further which, requires additional staff, usually nurses. The consultant is the one who consciously or unconsciously affects the level and pace of work in the hospital through his 'gatekeeper' function. Very occasionally is there a reduction in workloads. The CANO gave one example - midwives - because of the falling birth-rate. 'This problem has taken care of itself because few of the hospitals have a full establishment of midwives because of the non-
availability of staff’. A district officer in Beta maintained that the new Aberdeen formula for nurses would be used by the DNO to obtain more resources to improve staffing.

Consultation

Consultation is, as previous chapters have shown, a particular feature of the reorganised NHS, and it is a lengthy and complex process. In allocations of DF, the AEGs in Alpha and Beta were obliged to consult widely before final decisions on DF could be reached. Seeking the approval of professional advisory committees was time-consuming. As the Secretary of the SHHD observed at a conference in late November 1977 on the reorganised Scottish Health Service: 'I think we have paid an inescapable price in slower decision-making and many man hours spent in discussions with perhaps a disappointing outcome in terms of the value of so much earnest deliberation'. Consultative committees did not appear to act as a constraint in other ways. They all agreed with the allocations of DF proposed by the areas and districts (although in Year 1, Alpha's paramedical advisory committee expressed dissatisfaction over the way the lists had been compiled; however, it took no action beyond a written complaint to the AEG). It could be argued that these committees exerted a subtle influence on the decision-making process in that their very existence made officers more cautious in the recommendations they put before them for comment and approval. Certainly, officers were anxious to avoid lengthy delays which could have jeopardised the
implementation of developments, and were, therefore, not likely to wish to cause offence to any group. However, the case study provided no conclusive evidence either to support or refute this proposition.

Generally, the advisory committees' influence on the allocation process in respect to DF was peripheral in Year 1, and practically non-existent in Year 2 when funds were scarce. Had Year 2 followed a similar pattern to Year 1, advisory groups might have performed a more influential role since by then they would have established themselves. In Year 1, they were still in their infancy and were possibly unsure of their potential.

Consensus Decision-Making
Like consultation, consensus decision-making is a key feature of the new structure, with executive groups at area and district levels operating as consensus-forming teams. Reaching unanimous agreement, which was the whole basis of consensus, could on occasion take time. More significant, perhaps, it also presented difficulties for particular officers who were unsure of their precise role. For example, a DA in Beta found himself in a dilemma over the allocation of DF in his DEG. He was confronted by three professional officers, the DMO, DNO and DDO, all of whom claimed that their particular developments were top priority. What the DA wanted to know was who the arbitrator was? It could not be the DA because he had to reach a consensus with two of the professional officers, the DMO and DNO, and his coordinating role did not extend to an ability to arbitrate between various requests. Moreover, he was himself a
professional officer with direct responsibilities for ancillary staff. This kind of problem did not arise in the former BoM structure since lay boards performed this adjudication function, with the Secretary and Treasurer (a joint post) putting the choice to the board for decision. But there is no lay board at district level in the present structure; consequently, if proposals cannot be agreed upon by the DEG, then they must be referred to the area and, failing agreement at that level, to the board as a last resort. At the same time, however, districts were reluctant to refer to the area matters that lay within their jurisdiction since an action of this kind could be interpreted as incompetence on the part of the district team. The ever-present risk of having to refer decisions to the AEG worked to ensure that DEGs, wherever possible, reached their own decisions within a consensus framework. This did not solve the dilemma outlined by the DA mentioned above, and it could be argued, developments were approved by DEGs that might have received closer scrutiny had there been an individual, or a board of lay members, who could have performed this adjudicatory function. The AEG was ill-equipped to undertake it for reasons outlined in Chapter 11 (eg too remote; lack of time, etc), and the health board itself had to cope with so much business that it was unable even to give a great deal of attention to a scrutiny of development lists which had already been through district and area executive groups. Again, there was no direct evidence either to substantiate or refute the proposition that the consensus framework did tend to reinforce the
strategy of fair shares in the allocation of DF. However, the fact that this strategy was widely used in Alpha and Beta might have had something to do with the existence of consensus teams, although there were many other factors involved too. Moreover, many allocation practices and routines had been carried over into the reorganised service from the previous one. Nonetheless, the fact that through consensus and consultation more interests were involved in the process might have led to a reinforcement of the allocation of DF on the basis of fair shares.

Organisational Fragmentation

The fragmented nature of health board decision-making and administration precludes the comprehensive approach required for the effective resolution of problems affecting priorities and the allocation of DF, as well as other resources. Within the policy triad (health board, officers, advisory groups) there were numerous divisions, and each component of the triad had its own particular interests. Recent fashions in health service organisation have centred on increased functionalism and specialisation among the providers of services.\(^{(23)}\) The management structure itself exemplifies the fragmentation present. In Alpha and Beta there were three management levels - area, district and sector - and within each there were numerous competing interests. The spread of functional management has created further fragmentation and has increased the difficulties in reaching consensus decisions.

The experience of District Management Accountants (DMAs),
in their attempt to introduce concepts derived from a rational model of decision-making, illustrates the effect of fragmentation. The post of DMA was new with reorganisation and is one of the more innovative aspects of the new structure. Whereas previously, financial control in health authorities took the form of cost-accounting and bookkeeping, as described in Chapter 8, now financial management is concerned with the whole question of relating to needs the resources available within an overall budget. As a DMA in Alpha explained, the aim of financial management was to try and make better use of resources. Instead of basing your funding for future years on past allocations, what we're trying to do is build up budgets for all our expenditure heads with the users. We go out and talk to nurses and sector administrators. With information supplied by them, we prepare a budget and say to them 'that's your cash limit for (Year 2). We'll monitor back to you your performance against that'.

But this kind of exercise encountered problems. The DFO in Alpha explained that although a budget was prepared by the DMA, 'we (ie the DEG/health board) may not be able to fund that budget. So it's got to be adjusted'. The DMA gave an example of the difficulties that could arise:

We prepared a budget for patients' clothing at hospital X. They came back to us and said 'this is what we need'. No way did we have the money available. We had to cut back the budget and go back to the users and tell them what we had to take off.

This function of DMAs brought them into conflict with other disciplines. For example, among the more thorny of the problems experienced by the DFO and the DMA in Alpha, were departmental tensions between finance and administration.
I think one of the problems we have got in this area arises over the right of the DFO to go down to sector level and discuss matters with people. I'm not sure that this is accepted by our colleagues. I think they feel that maybe we're overstepping our remit. I don't think they see the DFO's role in the way it was identified originally, as being able to go to a sector administrator and saying, 'look, you're overspent here'. It'll be a few years before this aspect is settled.

The complexity of the management structure was, to some extent, a consequence of its fragmented nature. The area/district relationship, and the tensions arising from it, have been discussed in previous chapters. Perhaps these tensions were most evident in the role conflict arising from relations between AEGs and DEGs. District officers performed a dual role which contained many incompatibilities. For example, in a particular situation, should they remain loyal to the DEG of which they were members, or to their area counterparts to whom they were directly accountable? As was shown in the account of development fund allocations, there were occasions when district officers had to choose between these conflicting demands. The very existence of such tensions did nothing to improve area/district relations, particularly in the case of districts eager to overcome their essentially subservient position in the hierarchy. The consequent suspicion, and competitive postures, induced by this kind of fragmentation led to decisions on DF which were perhaps not always in the interest of health care for the area as a whole, although they may have been in the interests of particular district officers and functional managers anxious to gain what they could for their district or function. The approach to
savings, described in Chapter 12, is a clear example of how organisational fragmentation could act as a constraint, thereby circumscribing decision-makers' range of discretion. A further example concerned the nursing crises in Alpha and Beta which were recurring problems that distorted development fund allocations. It is almost certain that over-spending on the nursing budget was known to district officers before area officers learned of the situation and took immediate action to avert a financial crisis. Part of the explanation for the lack of communication, or for the delay in notifying the area, was the loyalty of district officers to the needs and services of their own district, as distinct from the needs of the area as a whole. This can be seen as evidence of the pluralist perspective of organisational dynamics discussed in Chapter 4.

Priority-Setting

This constraint was most in evidence in the allocation of DF since the allocations were about choices and priorities; inevitably so when funds were not available to do everything that was desired. Officers, especially at district level, experienced great difficulty in placing requests in order of priority. This probably explains why, in Alpha and Beta, most development requests were placed within the A category, with very few in the B category, and fewer still in the C category. While there were problems deciding between these categories, that is, what development should be A-rated, or B-rated or whatever, the knottiest problems arose when attempts were made to decide within categories,
particularly the A category since most developments fell into this. The choices were of the order of whether a dental officer should come before a nurse? Or whether a domestic should come before a doctor? Officers faced a dilemma over which categories of staff were more important at a particular point in time and, as one DMO said, 'one could never be absolutely certain that one had one's priorities right' - 'guesstimates' played a large part in the process. A DFO in Beta commented that in making decisions of this kind there was no formula; it had to be done through personal appraisal of each case. He found it an almost impossible task, especially when it was not possible to identify benefits that were clearly linked to particular developments.

How do you begin to evaluate the value of the services of, say, one more community nurse as opposed to improved nursing services to the mentally handicapped? To look at a set of accounts is just a record of where the money was spent. When you apply a cost-benefit approach, you can locate the cost but what's the benefit? You don't know. The best you can do is to say that the yield from that expenditure was so many inpatient days, so many operations in that specialty, so many visits by a health visitor, etc. Are you any further forward? How do you determine standards, or what output to expect? If, for example, one community nurse in her average day does eight visits, and another community nurse does fifteen visits - what does it mean? It's the quality of the service that is important but how do you measure this?

Decisions about priorities between different disease, or dependency, groups posed complex problems since they required cross comparisons to be made between different groups of the population who were suffering from different condi-
tions, and they raised fundamental value questions, such as, for example, how do decision-makers compare providing care for an elderly person with undertaking cardiac surgery for a middle-aged man suffering from heart disease? Decision-makers in Alpha and Beta faced this kind of dilemma, albeit indirectly, since their concern when allocating DF was with additional inputs, that is, more staff, rather than with particular client-groups or service categories. In such circumstances, it was all too easy to reduce priority-setting to a matter of life-and-death criteria, i.e. to 'waving the shroud'.(24) A typical example of this tactic was described in Chapter 12, when the CADO in Beta objected to the allocation of all available DF to the orthopaedic surgical unit. The Chairman of the AMC justified the decision on the grounds that lives would be saved. A District Management Accountant from Beta explained that the difficulty in the NHS was that a lot of decision-making and resource-allocation problems were political, by which he meant that there were rivalries among groups within the NHS each of which was intent on pursuing its own particular interests. For example, each head of department saw his, or her, sphere of interest as the most important, and deserving, one. The DMA said that an issue like the provision of kidney machines could arouse strong emotions. Thousands died from a lack of such machines, but thousands also died from cancer and heart disease. What the DMA was referring to was the inability to apply a rational model of decision-making, as outlined in Chapter 4, to an environment
which was so divided and fragmented with competing interests. It was a clear case of the demands of rational analysis being simply too great despite efforts to achieve it.

Staffing was another problematic area in priority-setting, and the DMA commented on the awkward choices which had to be made between, for example, doctors and porters. There might, as pointed out above, be situations where the latter were more important if a service was to be provided. Ancillary staff certainly became a priority in Alpha in Year 1 after a visit by the SHAS to one of its long-stay hospitals led to a decision being taken subsequently to boost domestic staffing. As a result of a comment by the SHAS on the level of domestic staffing, 8 additional members of staff were appointed, the cost being met by adjusting the list of developments for the particular hospital.

In the absence of hard, objective criteria, or of any overall strategy, for allocating DF, decision-makers had to make some sense of their environment and make some attempt to structure it in order to render it manageable. They achieved this by devising, and operating, their own strategies for allocating DF. These did not eliminate all conflict but they enabled decision-makers to reach decisions quite quickly within a framework which provided them with the necessary justification for reaching a particular decision.

Before proceeding to examine the coping strategies deployed in Alpha and Beta, it is appropriate to conclude this
section on constraints with a comment on the responses of the ten health boards which completed the questionnaire. In response to a question on the kinds of information used in reaching development fund allocation decisions, workloads, staffing norms, and comparisons with other boards were all mentioned. In terms of workloads, factors such as bed occupancy, patient attendances, and tests performed were all important. In addition, one board pointed out that a knowledge of the local situation was of tremendous benefit. Most of the boards tried to base their decisions, as far as possible, on factual information and projections (eg demographic trends). In addition, judgement and hunch were not uncommon elements in the allocation process. According to one board: 'Undoubtedly one must exercise judgement although hunches have been used successfully on occasion. Cases must be argued persuasively with back-up information as appropriate'. Another maintained that there was probably enough information to make decisions but that it was 'inevitable that sometimes the board and the AEG may be convinced by their feeling for the strength of an argument'. A third board argued that the lack of accepted staffing norms made judgement important, while according to one board, presentation played an important part. 'To argue emotively may well achieve more than a balanced statement of all the alternatives'. Finally, one of the boards stated that workloads and supporting information for developments was requested but could be improved upon.

It is suggested most decisions are taken by
either (a) necessity, (b) intuition, or (c) squeaking wheel - which must be 'greased' to stop the squeal for more staff, etc. This is partially true although we hope to develop modern mathematical techniques given the staff and information.

Overall, then, the responses to this question suggest that the practices observed in Alpha and Beta, and the problems they experienced, were not unique to them but were reasonably typical of practices, and experiences, in most other health boards.

In the next question, boards were asked to comment on the effect of seven constraints (time, existing services, inherited developments, lack of information, consultation, local government services, central guidance) on their allocation decisions. Six out of ten boards replied that all these constraints played a part, although some were more important than others, and varied from time to time according to the financial and/or political climate. One board replied that neither time nor consultation posed problems, whereas another board did not find local government services a constraint, or consultation and suffered little from the problem of inherited projects. For another board, the most important constraints were existing services which had to be maintained, or expanded, to cope with demand, and the problems arising out of the stringent requirements for consultation with a multitude of bodies before any alteration could be made. One board added a further constraint - technological progress, and cited the political and public pressures associated with transplantation operations. Another board, which replied that all the constraints listed
in the questionnaire had an impact on decisions affecting DF, went on to assert that the 'most difficult (constraint) to resolve and rationalise is the preconceived judgements met at all points because of narrow perspectives'. As with the previous question, the responses from health boards largely supported the findings which emerged from Alpha and Beta.

13.4 Coping Strategies

Wildavsky\(^{(28)}\) has written that in resource-allocation decision-making, aside from other complexities, there remains the imposing problem of making comparisons among different programmes that have different values for different people. It involves deciding such questions as how much intensive care units are worth as compared to geriatric facilities, health education, staff, etc. No common denominator among these functions has been developed. Officials discover they can't find any objective method of judging priorities among requests . . . (It is) necessary to develop mechanisms for helping men make decisions that are in some sense meaningful in a complicated world.

These, as the preceding discussion has attempted to show, are among the problems with which health board officers in Alpha and Beta grappled. As has been suggested,\(^{(29)}\) 'If it is sometimes easy to know what should not be done, it is seldom clear what should be done, or what can be done'. Decision-makers faced with situations of complexity and uncertainty, 'rely on decision rules, rules of thumb or standard operating procedures' that make decision-making manageable.\(^{(30)}\) In Alpha and Beta five decision rules, or coping strategies, were deployed by decision-makers at different times and in varying degrees. The coping strate-
gies are considered separately for analytical purposes. In practice, there was much overlap between them. All the strategies were intended as devices which structured the environment for decision-making; the first four described below relate specifically to the problems arising from the need to decide priorities with limited amounts of DF, while the final strategy refers to attempts by district administrators to obtain as large a slice of available DF as possible for their districts.

(a) Who Has Done All Right So Far?
If some group had done particularly well in a previous year, they would probably receive less in a subsequent year on the grounds that it was now someone else's turn. Examples of this strategy were quite common in Alpha and Beta. For instance, Alpha's laboratory service was allocated fewer DF in Year 1 on the grounds that it could not continue to expand at the same rate as it had enjoyed in past years. To some extent, the emphasis in both boards on community care in Year 1 was a consequence of the application of this strategy (but see next section on innovation). For example, the CANO in Alpha maintained that although community nursing had been favoured in Year 1, in Year 2 it might be the hospital service's turn.

I have concentrated on the community during this first year. I've neglected the hospital because I had to learn about the community. I didn't have to learn about hospitals. I've probably gone too far towards the community. We (ie nursing officers) looked at what facilities we had in the community compared with those we had in the hospital and we decided that the community facilities needed brought up to the standard found in the hospital service. We concentrated ... on
providing more health visitors, to increase our group attachments to GPs, and on increasing the numbers of nursing auxiliaries going into the community. On the hospital side we didn’t raise our staff establishments at all this year. We decided to leave them as they were because we didn’t have enough money to increase hospital and community staffing establishments. Next year as a result of what we find in our survey (ie of nursing establishments in hospitals) we would probably concentrate on our hospitals.

In other words, although the shift towards community care can be seen as an example of innovation (see below), the shift could very easily be short-lived if, after a time, administrators, like the CANO above, felt that this sector had received more than its fair share of available monies in which case the strategy of 'turn-and turn-about' would be employed, a variant of the fair shares strategy.

(b) Who Has Had Too Much in Relation to the Rest?
During development fund allocation meetings, particularly in Year 1, a great deal of horse-trading took place. If some group appeared to have received an 'over-generous' allocation at an early stage in the negotiations, some of this might be creamed off at a later stage in order to ease pressures elsewhere. For example, in one case, funds were initially allocated for three physiotherapists; by the end of the meeting this had been reduced to two. These often random, seemingly arbitrary, and usually last-minute decisions were sweetened with the frequently recurring comment: 'well, at least it's an improvement in the service'. In this way officers 'satisficed'. They did not try for the best of all possible worlds, but tried to avoid the worst in order to get by.
(c) Who Has Over/Underspent?

If a particular head of expenditure was overspent, then it was unlikely to receive additional funds (with the possible exception of nursing, for the historical reasons outlined in Chapter 11) as a sanction against further overspending. If underspending occurred, questions were likely to be asked concerning the appropriateness of further allocations if the possibility existed that they would not be spent during the financial year.

These three decision rules, or coping strategies, all formed part of an over-arching allocation strategy, **fair shares**. As mentioned in the section above on the importance of DF, these funds were invariably allocated on the basis of fair shares all round, rather than on the basis of directing all available funds to one particular development. But there were a few exceptions to this general rule. As described in Chapter 12, Beta used all of its DF for Year 2 on one particular development - the opening of a new orthopaedic unit which required staffing. Moreover, crisis situations, such as the recurring nursing recruitment problems in both health boards, could alter development plans and involve the bulk of available monies being channelled into one activity to 'put out the fire'. Nevertheless, it was generally the case that a strategy of fair shares was pursued, with small sums being allocated to as many groups as possible. Naturally, this strategy had the effect (whether intended or unintended makes little difference) of perpetuating the existing pattern of service provision which, correspondingly, lessened the chances of introducing any
major innovations in the direction taken by particular services. And even if shifts in service delivery patterns and priorities did occur, as in the example of community care (see below), these tended to be the result not so much of some rational objective assessment of need (however defined), but the outcome of more subjective criteria like political fashion, public pressure, resource scarcity, and so on. Just as many of these pressures frequently worked to produce decisions which reflected a commitment to existing services, so, too, could they result in decisions of a somewhat different nature.

(d) Who Will it Hurt Least?
When deciding development fund allocations, officers might be anxious to try to narrow down the number of competing claims by eliminating those staff categories which might be able to do without an injection of funds. For example, it was always possible that one of the ancillary services, which had no direct impact on the treatment of patients, could afford to wait a bit longer for improvement. For instance, in Alpha, district 'A's' original development lists for Year 1 featured a request for eight domestic staff at a mental hospital in the district. The request did not appear on the revised lists (it was not an A-rated development), and would probably have remained on the lists for possible funding in a subsequent year had it not been for a visit to the hospital by a team from SHAS. As described in Chapter 11, in the light of the team's report, the AEG asked the district to review its decision not to fund this particular development. This example also raises some interest-
ing questions about how particular developments become A priorities while others do not. If a visit by an inspect- orate can change a non-priority to a priority merely on the basis of the anticipation of the team's report, then it suggests that officers themselves must be unsure of the certainty of their banding procedures. In this particular district, most of the A-rated development requests were for community nurses and they absorbed the bulk of available DF in Year 1.

In the questionnaire circulated to the remaining thirteen health boards in Scotland, boards were asked to comment on three allocation strategies: (i) fair shares, (ii) who will it hurt least? and (iii) who has done all right so far?(31) The question was a difficult one for health boards to answer, particularly as it could be misconstrued as implying criticism of the way in which boards allocated their DF. Consequently, some answers were evasive (eg 'We try to follow the board's known policy which is in line with The Way Ahead'), and others were somewhat curt (eg 'Service priorities are the deciding factors'). Of the ten boards which responded to the questionnaire, three stated directly that the strategies cited were not applicable to them (although one expressed this view with more certainty than the other two); four were less direct so it was not possible to know for certain whether they were dismissive of the strategies because they were inapplicable, or whether they accepted their value but just did not want to appear to condone such 'irrational' practices; and the remaining
three stated that these strategies did play a part in the development fund allocation process. One of the boards in this last category replied that while the principal strategy must always be 'where the current need is seen to be, nonetheless one is aware of examples such as those quoted', ie strategies (i), (ii) and (iii). A second board replied that strategies (i) and (iii) were used, adding that there was not an awareness of using strategies of this kind 'except to spread the largesse, when available, around and to spot really serious deficiencies. The third board in this category replied: 'I think it is fair to say that all of these strategies are used to some extent or another. (i) and (iii) would certainly be factors in reaching the final decision'. Strategy (ii) was less useful although 'we are aware of this'. In practice, if a group did not present a 'good case' it would be discounted at a very early stage.

From these data, it is possible to conclude that the strategies employed in Alpha and Beta were not unique to those boards. At the same time, it is not possible to be certain to what extent the strategies were present in other boards. Since many of the replies to this question were rather guarded or, in some cases, equivocal, it would be necessary to probe more deeply before coming to any definite conclusions. Perhaps the medium of a questionnaire is unsuitable for exploring sensitive areas of this kind. Nevertheless, responses from three of the boards supported the findings from Alpha and Beta.
This strategy was of a different order from the rest since it was not so much concerned with setting priorities (not directly at any rate) as with assisting district officers to circumvent the idiosyncracies and rigidities of the budgeting system which operated in health boards, and to enable them to pursue the interests of their particular districts as vigorously as possible. A DA in Alpha explained the rationale behind the tactics which formed this strategy:

what I'm doing is in the best interests of (this) district and that's within the rules and regulations of course. I would bend these as far as I possibly could to get what I think is needed done in this district. But although I'm prepared to bend them, I'm not prepared to break them. I think I would be failing in my duty if I just sat back and let things overtake me. You've got to have your ears to the ground and your eyes open and if there's any way to obtain more resources then it must be pursued. The way I see it the more money I get coming over (here) which is our own money and free for our own devices, the more I'm in a position to help out when there is a sudden crisis ... we've got a bit to play with ... I can do something about it.

Various tactics were available; for instance, according to the DA,

If you're underspent in a certain category, you're quite free to divert that temporarily. You can't swing it away forever - that is more a policy matter. We should be able to make temporary changes - to play it by ear, or off the cuff, as the year's progressing.

Switching revenue from one head of expenditure to another was not always straightforward, particularly where nursing was concerned. The DA explained:

There is lying in the development monies, from previous years, money that was won to employ senior enrolled nurses at hospital X. We can
only pull this money away from the area when we go up and say we've made the appointments. Well, I would have taken a bit of a chance and gone up and said 'Right, we've made the appointments'. I would have said that we had upgraded the nurses. I was anxious to get (the money) over here because that would have upped our budget. Having got it here even although we hadn't upgraded the nurses, the money was still there. I could then use it to buy furniture until such time as the nurses were upgraded. The money was there for that purpose - that would be its first priority. While we're waiting on them getting it (ie once they had qualified), I'd use the money on other things.

The district used this advance appointments device in Year 1 prior to the DF being frozen as a result of the nursing staff crisis. The DA maintained that only by using this device were they able to prevent all developments being postponed. Another tactic available concerned wage awards. When a wage award comes along, for instance, we claim that automatically. I think everybody takes a little bit of licence when they are making these bids. If you don't overdo it you'll get away with it. You claim a little bit more than it will cost you in practice. This is yet another way of gradually building up and getting yourself into a better financial position, which then allows you a bit more freedom. It's a very small thing but if you're doing it with the nursing award and when the clerical and administrative award comes along and a domestic award comes along and you're making a bit every time, it all helps. You can't ask for the moon. They (ie SHHD) can't pin you exactly and if you don't go over the score you can get away with it. This applies when we're bidding for new capital schemes. You've got to make a bid for the running costs. If you do a little over-estimating, it's OK. Any administrator is trying to get as much money as he can. The controls that are placed on us lead us to adopting such strategies.

It was pointed out in Chapter 12 how in one of Alpha's districts, because of the limited DF available in Year 2, officers looked for ways of appointing staff on a temporary basis for six months or so by using non-recurring funds for
recurring purposes.

Another tactic available to obtain 'extra' resources for immediate use was the mortgaging of the following year's DF. District 'B' in Alpha contemplated using this tactic but refrained from doing so. The tactic was of potential value in obviating the need for savage pruning of development requests, since a district could submit requests totalling more than the funds available knowing that it was extremely unlikely that anything approaching this amount would actually be spent (i.e. which meant that the district would in fact keep within its original allocation but without actually having to make cuts). In the event that the amount might be spent, then the district would be overspent and would mortgage the following year's funds. This was a risky exercise in view of the possibility of a total freeze on public spending in the NHS and, in fact, in Year 2 officers in Beta made it clear that no more mortgaging of DF was to be permitted because of the uncertainty surrounding budgetary arrangements and public spending trends. A variant of mortgaging the following year's funds was to anticipate 'slippage' in capital schemes (which released funds, known as 'windfalls', for non-recurring purposes) by over-committing your funds at the start of the year (funds from capital schemes were not released until September or October). Treasurers accepted over-commitment on the capital side through intelligent anticipation. They were not anxious to encourage over-commitment on the revenue side.
All these various tactics, some of which were actually used while others lay dormant ready for use if necessary and if possible, illustrated that most officers, particularly at district level, where they were trying to gain access to funds controlled at area level, saw one of their tasks as obtaining as large a share as possible of available monies for their own purposes.

13.5 The Scope for Innovation
Despite all the problems and constraints facing decision-makers, they are occasionally able to make changes in policy. There are numerous pressures for policy change and sometimes these, either separately or combined, are powerful enough to bring about breaks in precedent. Changes in public opinion, the appearance of crises, and the availability, or non-availability, of financial resources are all capable of giving an impetus to dramatic shifts in policy.

All allocations of DF were relatively incremental, although a few were more incremental than others and fewer still marked new departures. In Alpha and Beta there were no dramatic policy shifts, but the example of community care services illustrates that it is unwise to generalise about the impossibility of bringing about any change in the NHS. Change may be very difficult to introduce for the reasons already given, but the emphasis on community health services, particularly in Year 1, while not resulting in major differences in the quality of, or balance between, services, was an example of how change could occur at the margin, as distinct from the more common practice, or routine, of
adding to an existing base. In short, it was a departure from the ratchet principle governing most allocations, whereby existing services were added to each year and the commitment to an ongoing system of service provision was reinforced. A number of factors accounted for this policy shift, including those already mentioned, namely, public opinion, crisis, and finance.

First, many administrators were acutely aware of a feeling among those providing community health services that reorganisation was nothing more than a takeover of the entire health service by the hospital service. Health boards were looked upon as old RHBs in disguise. An obvious way of overcoming these fears and suspicions was to channel resources into community health services in order to show the good faith of the administrators and to prove to those working in this sector that the administration had their interests very much at heart. Therefore, bureaucratic change through reorganisation, which led to an integrated health service, was responsible, in part, for focusing attention on community health.

Second, a related factor was that the community health services inherited by health boards from local health authorities in 1974 required urgent attention since many had been seriously neglected and were substandard. Boards simply could not ignore these deficiencies which put community health services in the category of 'poor relation' to the well-endowed hospital service.

Third, the political climate in the mid-1970s was well dis-
posed to a policy initiative of this kind. By 1974, community care had become politically fashionable as well as attractive economically. As the economic situation continued to deteriorate, while the cost of running the NHS continued to rise, the appeal of community care as a policy priority increased. Economic reasons and motives prevailed although these were laced with humanitarian ideals. It was claimed to be cheaper to treat people at home, instead of putting them into costly institutional surroundings (this remains to be proven, although there is some evidence which questions this view), and it was also widely believed that institutionalising patients was demoralising and dehumanising. Reorganisation, through integration, was an attempt to develop community services in order to relieve the pressures on hospitals, particularly acute beds occupied by long-stay patients who ought not to have been in hospital. This, as has already been mentioned, was an acute problem in Beta. With national politicians and a number of pressure groups favouring community care, albeit for different reasons, officers in Alpha and Beta, especially the former, responded accordingly. They had a clear objective to move towards (outlined, for instance, in the priorities memorandum, The Way Ahead), and one with which they agreed, as the discussion of allocation processes in Chapters 11 and 12 revealed. The development of, and priority given to, community health services was the outcome of an awareness of the limited resources that would be made available to the NHS in the future. Local and national considerations converged on
the same objective and officers perceived community care as offering some kind of solution to, or relief from, numerous near-intolerable pressures on the hospital service.

These factors, then, played a significant, if not a decisive, part in creating a climate favourable to community care services. Provided a certain climate exists, that is, one where there is broad consensus among all interested parties, it seems likely that change will be possible. Not that the emphasis on community care led to dramatic, or sustained, shifts in resources. Nevertheless, the changes that occurred are worthy of note. Nationally (ie Scotland), in 1974/75, hospital services accounted for over 72% of total expenditure with the community health service for over 5%; and in 1975/76, the figures were over 70% and over 6% respectively; finally, in 1976/77 the figures were just under 70% of the total and just under 6% respectively. The drop in expenditure on the hospital service has been largely due to declines in capital investment. In Alpha and Beta, spending patterns mirrored national trends, although there were slight variations between the two boards. In Alpha, a breakdown of the districts' developments authorised for funding in Year 1, and described in Chapter 11, revealed a small swing to community health services. While the emphasis on these services varied between the two districts within Alpha, there was an overall area-wide bias towards the community sector. The position in Alpha is shown in Table 13.1 which comprises a review of spending trends on revenue account over the four-year period since
reorganisation, 1974/75 to 1977/78. Although the proportion of total revenue expenditure on community health services increased by a mere 0.3% (a large part of this increase went on the cost of a new Domiciliary Night Nursing Service) between 1974/75 and 1975/76, the table shows that an overall commitment to community care was not sustained beyond Year 1. Between 1975/76 and 1977/78, spending on community health services began to fall until in 1977/78 it was 0.1% below the level it had been in 1974/75 and this at a time when the priorities memorandum stated that continued improvements in community health services were desirable. As Table 13.1 shows, expenditure on the hospital service fell during this period in line with the national picture. The sector which increased its share of available funds throughout the period was primary care. It has been pointed out elsewhere that primary care services are largely demand determined and are not susceptible to administrative control. Moreover, the status of GPs as independent contractors reduces the scope for influencing their numbers. Expenditure on drugs is determined mainly by considerations of demand and professional practice. It is more than likely that a combination of these factors was responsible for increased spending in this sector. The increase in pharmaceutical costs in the period 1974 to 1978 was caused in part by the introduction of new family planning provisions in 1975 which included the prescribing of oral contraceptives by GPs. Because of the contractual relationship, primary care services constitute an open-ended commit-
ment financially; the SHHD makes available funds to the level of the actual expenditure involved.

TABLE 13.1 Percentage Distribution of Revenue Expenditure on Hospital, Community and Primary Care Services 1974/75 - 1977/78 (Alpha)

<table>
<thead>
<tr>
<th>Percentage Distribution</th>
<th>Hospital*</th>
<th>Community</th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1974/75</td>
<td>64.9</td>
<td>8.3</td>
<td>24.6</td>
</tr>
<tr>
<td>Year 1975/76</td>
<td>63.7</td>
<td>8.6</td>
<td>25.4</td>
</tr>
<tr>
<td>Year 1976/77</td>
<td>63.0</td>
<td>8.5</td>
<td>26.5</td>
</tr>
<tr>
<td>Year 1977/78</td>
<td>63.1</td>
<td>8.2</td>
<td>26.5</td>
</tr>
</tbody>
</table>

* Total includes ancillary services, associated services and specialist services costs.

Source: Financial Reviews (Alpha)

A closer look at revenue expenditure in Alpha between 1974/75 - 1975/76 suggests that community health services did rather well in terms of real growth in Year 1 (see Table 13.2). In the hospital service, the real growth rate amounted to 4.1%, while in the community and school health services the growth element amounted to 9.9%. In terms of overall percentage increase in revenue expenditure, community health services did proportionately better than hospital services by 4.1%.

TABLE 13.2 Revenue Expenditure - Percentage Increase 1974/75 - 1975/76 (Alpha)

<table>
<thead>
<tr>
<th></th>
<th>1974/75</th>
<th>1975/76</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Services</td>
<td>£11,955,377</td>
<td>£15,993,106</td>
<td>33.8</td>
</tr>
<tr>
<td>Community &amp; School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Services</td>
<td>1,512,371</td>
<td>2,086,158</td>
<td>37.9</td>
</tr>
</tbody>
</table>

Source: Financial Review (Alpha)
In Beta, as Table 13.3 shows, the revenue expenditure position was broadly similar to that prevailing in Alpha. However, the situation in regard to community health services was more static; there was practically no movement between this sector and the hospital service with the exception of the year between 1974/75 and 1975/76 when spending on community services fell by 0.1%. There were greater fluctuations between the hospital service and primary care services over the four-year period. Nevertheless, Beta was able to achieve some redistribution of resources within the hospital service. Between 1974/75 and 1975/76, total hospital running costs showed that there had been a movement of 1.1% in resources from the acute hospitals to the long-stay hospitals. This swing was chiefly brought about by nursing staff increases at two large hospitals in the area. Although events in Year 1 in Beta in regard to development fund allocations were not observed directly, it was pointed out in Chapter 11 how severe nurse staffing problems at these hospitals had led to most of the DF being directed towards improving staffing ratios. However, while this movement was in line with national policy in regard to long-stay hospitals, it resulted not so much from a consideration of all the alternative options facing officers (ie a calculated decision) but from the staffing crisis at the hospitals to which officers had little alternative but to attend. Moreover, this movement was not sustained between 1975/76 and 1976/77 when spending patterns reverted to their position in 1974/75. There was a slight improvement between 1976/77 and 1977/78.
TABLE 13.3 Percentage Distribution of Revenue Expenditure on Hospital, Community & Primary Care Services 1974/75 - 1977/78 (Beta)

<table>
<thead>
<tr>
<th>Percentage Distribution</th>
<th>Hospital*</th>
<th>Community</th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1974/75</td>
<td>67.6</td>
<td>6.2</td>
<td>19.5</td>
</tr>
<tr>
<td>Year 1975/76</td>
<td>65.7</td>
<td>6.1</td>
<td>20.3</td>
</tr>
<tr>
<td>Year 1976/77</td>
<td>65.2</td>
<td>6.2</td>
<td>21.3</td>
</tr>
<tr>
<td>Year 1977/78</td>
<td>65.8</td>
<td>6.2</td>
<td>21.1</td>
</tr>
</tbody>
</table>

* Total includes ancillary services, associated services and specialist services costs.

Source: Financial Reviews (Beta)

Although the case study only covered a two-year period, a review of spending trends in Alpha and Beta over the four-year period since reorganisation suggests an overall picture of policy maintenance with only occasional slight shifts in expenditure which are not sustained beyond a year or so. In Alpha, the small swing to community care was an example of innovation (at least in relative terms) but it was not sustained beyond Year 1 of the research. It is difficult to account for the reasons for the fluctuations. Obviously the shortage of DF in Year 2 and beyond was a factor which possibly added to the difficulties and general organisational inertia which worked against any policy change. On the other hand, the fluctuations (which were also apparent in Beta although not in the community services which presented a fairly static picture) probably reflected the potency and persistence of a fair shares allocation strategy coupled with its turn-and-turn-about variant.

Whatever the explanations, clearly policy change at local
level was minimal and not enough to disturb an overall national picture of policy stasis. Nonetheless, it would be a mistake to overlook the micro shifts that did occur since these were indicative of some discretionary activity at local level. The fact that there were subtle differences between Alpha and Beta in their spending patterns over a number of years lends added weight to the view that health boards do possess a degree of autonomy and exercise some discretion over their resource allocations. It has not been the purpose of the present research to explore inter-health board variations so it is neither possible nor, indeed, relevant to go beyond what has been written above.

By way of conclusion, all that can be said about the scope for innovation is that a favourable climate at national and local levels can facilitate change albeit of a limited kind. However, a more potent factor in decisions on the allocation of DF would appear to be the concept of fair shares which renders policy change either extremely unlikely, or, at best, temporary as each year brings with it fresh demands from existing services.

13.6 An Assessment

The general rule governing the allocation of DF in Alpha and Beta was that 'something is better than nothing'. A policy of appeasement was preferred, the aim being to keep as many people happy as possible. Administrators, on the whole, were ambivalent about the merits of their approach to allocating DF. On the one hand, they believed it to be unsatisfactory and that the only way to improve a service
dramatically was to channel the whole of the available development monies into a particular area which was obviously underfinanced; in short, there should be less and less of little bits of money spent here and there. On the other hand, the nature of the environment within which administrators operated was hostile to such an approach but well suited to a fair shares strategy which was tailor-made to the requirements of a situation where resources were not available to cope with all demands placed upon them and yet where there were numerous equally competing demands to be placated with the monies that were available. As administrators argued, what do you do when there are so many understaffed areas and so many which require to be strengthened. Consequently, there may well be something to be said for trying to improve a little bit here and there. While in theory other policy options might have been usefully explored, in practice, administrators, even at area level where policy planning should occur, were predominantly concerned with short-term considerations and the solutions they reached, and the allocation strategies adopted by them in response to particular pressures, reflected this short-term, 'crisis management' approach to allocation decisions. A DA in Beta summed up the views of many administrators when he acknowledged that various inefficient practices, such as differing lengths of stay in hospitals within the district, existed but that 'the officers had done nothing. There was no need. When 'new' money came in annually, there was no incentive to question existing practices or resource usage'. Even when, in Year
2, DF were reduced, many administrators saw themselves performing a holding operation until a period of 'normalcy' returned.

The allocation strategy of fair shares, whereby everyone received something if at all possible, might also be termed the ratchet principle, that is, each group received the same as the previous year only more if possible. Terms like incrementalism and satisficing may be used to describe the process. Incremental change, as was discussed in Chapter 4, involves policy being made in a sequence of incremental steps. Decisions are rendered manageable through incrementalism since it is not expected that problems will actually be solved, merely that improvements will be made. Incrementalism, as it applied to the allocation of DF, did not involve debating grand health policy goals, nor did it entail a reassessment of the benefits and costs of existing services. Furthermore, incrementalism normally meant allocations for improvements and/or expansions rather than the start of new developments.

However, usage of the term incrementalism is suggestive of a more ordered sequence of events than actually occurred in Alpha and Beta. In view of the allocation process described in the last two chapters, it would appear that its disjointedness needs to be emphasised. The use of this term here accords with Braybrooke and Lindblom's secondary meaning. Although the dual definition of the term was discussed in Chapter 4, it is worth repeating the main points. Primarily, the authors are interested in disjointedness in
the sense of fragmentation, that is,

analysis and evaluation are disjointed in the
sense that various aspects of ... any one problem
or problem area are analysed at various points,
with no apparent coordination and without the arti-
culation of parts that ideally characterises
subdivision of topic in synoptic problem solving.(34)

While there were elements of this meaning of disjointedness
present in the allocation process, for example, in the
relations between areas and districts, and in the relations
between officers both within and between different
tiers, perhaps more apparent was the presence of disjointedness in Braybrooke and Lindblom's secondary meaning:
'... analysis and evaluation are ... disjointed because they focus as heavily as they do on remedial policies that 'happen' to be at hand...'.(35) Decisions on DF were often disjointed in this sense. For example, when pruning and trimming occurred, the operation to allocate funds became a brutal horse-trading one which resulted in crude trade-offs between staff establishments. For example, one radiographer might be agreed to if only two physiotherapists were recruited instead of the three originally requested, and so on. Furthermore, increasing staff establishments was the favoured policy option. There was never any serious attempt made to explore other solutions to problems of increasing pressures on staff. In general, allocating funds became less a matter of whether the appropriate services were being developed in an appropriate direction (and a fundamental problem was in deciding what was meant by 'an appropriate direction') and more a matter of placating as many groups as possible. Allocating DF meant, in effect,
a reinforcement of existing services and policies. It was a process that proceeded from a reasonably firm historical base that remained unaltered and one that was overwhelmingly guided by notions of fair shares all round.

Finally, it is interesting to consider the role of board members in the allocation of DF. As preceding chapters will have made clear, the allocation process was characterised by a small number of key actors who determined how the funds were to be spent. This group was composed of officers at area and district levels and it was their task to assemble the list of proposed allocations that went forward to the board, via its principal standing committee, for approval. Although board members were presented with opportunities to query proposals, the discussion in Chapter 7 shows how difficult it was in practice to perform such a role when expertise and motivation were lacking. Moreover, the allocation process was structured in such a way that it insulated the key decision-makers from lay involvement.

The organisational processes surrounding allocations of DF were evidence of this. All meetings over DF prior to the board's pro forma acceptance of the final package were private. In addition, requests for DF were not generated within the board. They were, in most cases, demands created by staff, what Danziger(36) has termed 'withinputs'. These 'bright ideas' were transmitted up through sector, district to area. Therefore, the operation of the resource allocation process had the effect of insulating those with decision-making discretion, in particular the officers, from public demands, as expressed through board members, and from
visibility. Such insulation might just be defensible if the decision process was extremely complex and technical. But much of the process observed involved political judgements concerning what constituted priorities and so on. Subjective criteria frequently governed what was deemed relevant or irrelevant in the way of developments. Moreover, while accepting the value-laden nature of priority-setting, one administrator\(^{(37)}\) is of the opinion that the obstacles to meaningful lay participation are so great that 'decisions about priorities will, of necessity, be made by professionals - administrative, medical or political - even if this introduces an element of paternalism'. While these comments are directed primarily at LHCs, whose task it is to represent the views of the public to health authorities, they have a direct bearing on the feelings of frustration and impotence experienced by many board members in Alpha and Beta. Given the nature of decision-making over DF as it has been described, it is perhaps not surprising that many members felt remote from what was actually happening within their own board.
Most of the evidence suggests that real management work is characterised by variety, discontinuity and brevity. Managers work in power networks, armed with informal information and at high speed. Decision-making, one of the main planks of the rational/scientific management idea, tends to be done through the seat of the pants, or off the top of the head, or in some other place, but rarely in an orderly, 'scientific' fashion.


The concluding comments are in two sections. First, conclusions are drawn from the case study of the allocation of DF; and second, there is an attempt to draw some overall conclusions from the thesis in order to tie in the case study with earlier material on reorganisation and the drive to improve management and decision-making in the NHS. The chapter ends with a third section on the research's implications for policy.

14.1 Conclusions (1) The Case Study

Chapters 11 to 13 have attempted, through description and analysis, to present a picture of resource-allocation processes as these applied to DF in two reasonably typical health boards, Alpha and Beta, over a two-year period. The narrative attempted specifically to reconstruct the allocation process as defined by the decision-makers.

As a general observation, it would not be unfair to describe the decision-making process concerning DF as consisting largely of administering and maintaining a system
rather than of making fundamental changes in it. Much of the discussion about change, and the need to set new priorities which may have led to large-scale changes, or may have necessitated such changes (for example, a commitment to preventive care), tended to remain at the level of symbolic posturing ('coffee table chat') rather than find itself translated into actual allocation decisions. Of course, significant changes would take many years to achieve but, even making allowances of this kind, there is some validity in the view that talk of change served as an acceptable substitute for a real commitment to it through positive action. In other words, the more officers commented on how long overdue change in health policy was in coming, the more they convinced themselves that change would occur. It may be that a new climate had to emerge before action could proceed and that the rhetoric of planning and better resource use was designed to achieve this. Moreover, change was not impossible within the confines of the present allocation procedures, although it was rare and of a limited nature. Developments largely meant 'more of the same' through improvements and expansions rather than significant new departures. In general, decision-making was biased overwhelmingly towards attending to the arrangements of the health care system rather than towards making the arrangements, a consequence in part of the numerous constraints operating on decision-makers and a state of affairs which is captured by the notion of 'non-decision-making' discussed in Chapter 4. This mode of operation largely accounted for the way in which the hospital service
continued to absorb the bulk of available resources. The basic expenditure patterns, as explained in Chapter 10, had their origin in the days before the NHS was created and they had not been questioned over the years, that is, not until the SHHD's SHARE report. The bulk of expenditure was simply re-enacted each year without being challenged. Even so, SHARE is not concerned with resource-allocation within health boards but only with allocations between them.

The purpose of this research has been to discover why the system operated as it did at local level, and to do this through finding out how decision-makers themselves explained and accounted for their actions. The decision process surrounding DF was, as the description in Chapters 11 and 12 showed, complicated, in that it involved large numbers of people at different levels of the health board structure all representing different interests. It was also fragmented - not only were there two main tiers involved in the allocation process, areas and districts, but there was an array of other bodies whose requests for developments had to be sought, and whose views on the proposed allocations were required. It was noted in Chapter 4 that the organisational setting in health boards was a plural one, consisting of groups competing against each other (for part of the time, at any rate), and having different views about the nature of health, health services and their place in these, rather than sharing a common view on such matters. In addition to complexity and fragmenta-
tion, there was disjointedness - decision-makers did not
follow a plan as such but were more inclined to follow their instincts which had been sharpened over many years of experience. Resources were allocated in ways that seemed most feasible at the time, rather than in ways that always reflected what were supposed to be priorities (as laid down, for example, in the SHHD's priorities memorandum); 'putting out fires' (like the nursing staff crises in Alpha and Beta caused by overspending) absorbed more attention and DF than the initiation, or development, of what were supposed to be board priorities. At best, officers were engaged in a juggling act and, if possible, tried to do a little of both, that is, put out fires and allocate small amounts to new developments.

The problems posed by a decision process that was complex, fragmented and disjointed were not caused by a lack of information per se, since information did exist to assist those responsible for allocating DF. Whether this information was assembled correctly, or used to its best advantage, were different matters, of a political, as well as technical, complexion. Information is a highly valued commodity the possession of which confers power and status. Accordingly, the acquisition and use of data in decision-making cease to be purely technical activities and become part of a political process. For example, staffing norms exist in nursing, and various paramedical groups are moving in a similar direction. Although norms are looked upon as assets in that they provide decision-makers with firm guidelines and clear criteria of staffing need, there is, never-
theless, a problem concerning the reliability of these norms, not to mention their practicability in certain situations. Invariably, the norms tend to veer towards the ideal rather than being geared to solving existing problems in an acceptable way. This was why administrators in Alpha and Beta often made comparisons with staffing levels in other comparable boards rather than keep to the established norms with their inbuilt escalatory tendencies. The ability of norms to assist decision-makers were of limited usefulness when, for example, understaffing was present in several areas of nursing and all these gaps were listed as A priorities - how was one then supposed to decide whose requirements were the most urgent? For instance, if a health board had a low level of nursing staff in a mental hospital and a low level of community nursing staff, the problem became one of deciding which had the higher priority. Faced with these dilemmas of choice, administrators coped in various ways, but particularly in their use of certain coping strategies such as those described in the last chapter. Submissions for DF always outstripped the funds available. Therefore, pruning and trimming became necessary so that the lists of requests for funds could be brought into line with available resources. These were the principal weapons in the armoury of administrators engaged in the allocation exercise. The reference to weapons is not inappropriate - the allocation process, according to one DA, could be quite bloody.

Development lists could best be described as 'shopping-
lists' of deficiencies - they were not linked to any specific policy objectives, or to any broad development strategy. Lists were compiled from requests received direct from staff, from heads of departments, and through other channels. From the start, therefore, decision-makers were engaged in a reactive process as opposed to an anticipatory process. Moreover, because it involved asking staff about their wants, needs, shortages and pressure points, the whole exercise merely served to raise expectations which administrators then had to try and satisfy. Indeed, some members of the AEG in Alpha were not altogether happy with the development lists system. For instance, did the lists reflect 'need', or 'demand', and how reliable were they? The AEG was sceptical of the lists and the claims contained in them. It was not simply that the 'insurance principle' was at work, whereby requirements were deliberately overstated so that some requests might receive funding, but that the opposite might also be occurring, that is, the 'resignation principle', whereby the lists understated requirements because staff had not bothered to submit requests since they did not think they were likely to be successful in having any of them met. If, indeed, this was what was happening, then it was an argument in favour of the fair shares allocation strategy because, by attempting to give as many people as possible a little of what they asked for, then it was more likely that they would not despair of the system and would submit a fair assessment of their requirements. The extent to which requests reflected need rather than demand, and vice versa, has never been an
easy question to answer where health services are concerned. Since it is widely accepted that 'need', a relative concept, is professionally defined, the dividing line between need and demand is extremely hazy.

Having received the long lists of submissions, the officers, at district and area, reviewed them and concentrated on each submission in isolation, without relating it to any particular goals or objectives. Exceptions did occur, especially in Year 2 when there was a greater awareness among officers of the need to make choices because of resource constraints, but they remained exceptions. For example, a DA during an allocation meeting with other DOs pointed out that a particular request for additional staff was in line with board policy on, say, geriatric care, or, conversely, that a request for a heart specialist would go against board policy if acceded to. But the overall tendency was to review each development in a vacuum, with decisions being taken in a piecemeal fashion. While this approach prevented any examination of the total situation in regard to health policy, and of alternative ways of allocating resources, it was simpler for a decision-maker to 'separate' problems in this way. At the same time, there did exist an inertia, whereby it was easier to agree to new appointments rather than to look beyond the immediate need for additional staff in order to examine the form of care provided and possibly alter this. As has been stated several times already, new staff appointment decisions were important because little-by-little they altered, or, more
usually, reinforced, the pattern of care and the board was then committed to this pattern. If the trend was to reinforce existing patterns of care through additional appointments, then altering the status quo became increasingly difficult. But administrators rarely looked at a problem, or at a request for more staff, with panoramic vision - they reduced a problem in size, often without even being aware they were doing so, and considered only a limited number of options to resolve it. The restriction of vision was also a consequence of the numerous constraints which impinged on decision-makers and made up the environment within which they operated. Some of these, like the pressure of time, were technical; others, like the pressure to be fair and to allocate DF in such a way that as many groups as possible derived some benefit from them, were more political. District 'B' (Alpha) was aware of some of these problems and, in Year 2, adopted a different approach to compiling development lists and ordering priorities. However, because of the absence of growth monies it was difficult to determine how successful the new procedures were. It certainly did not obviate the need for choices between competing claims of equal merit.

Of course, changes might occur in this style of decision-making as a result of the publication of the SHHD's strategy memorandum, The Way Ahead, and subsequent developments, although at the time of the present study it was far too early to tell. As mentioned in an earlier chapter, only initial reactions to the document were observed, and these
varied. For instance, board members were quite enthusiastic about it, whereas officers, on the whole tended to the view that the document said nothing new and was very general in its assessment of priorities which reduced its relevance. In particular the document took no account of local gaps in services, including those services it recommended should not continue to grow. Moreover, the political problems, and many of the technical obstacles, remained despite the appearance of the document. It is difficult to see how subsequent developments, such as the issuing of further guidelines on priorities to health boards, will overcome these. However, what the case study does reveal are the obstacles and entrenched operational routines that will have to be tackled if progress is to be made in equalising service provision within boards. While techniques like management accounting and programme budgeting may better inform decision-making and the choices available, by improving the visibility of allocations, they may, paradoxically, reinforce policy stasis rather than improve the chances of introducing change. It was pointed out in Chapter 8 that the use of rational techniques in government (eg the PESC experience) served to reinforce incrementalism - the opposite outcome from that intended. Therefore, the obstacles to be overcome are political rather than ones of technique alone. Even the existence of consensus management teams may make the introduction of policy change more difficult because the agreement of so many interests is essential. Although administrators utilised a number of strategies to
structure their complex, fragmented and disjointed environment, a major conflict, which was implicit rather than explicit, remained concerning whether DF should be used primarily to change the direction of the service provided, or whether they should be used instead to plug gaps in existing services. If you did one, you had considerably less freedom to do the other, and an emphasis on plugging gaps made it increasingly difficult to bring about policy shifts because existing services were being continually reinforced. By adding to the vested interests associated with existing services, which was the inevitable outcome of a 'more of the same' allocation strategy, one thereby added to the annual clamour for more resources which emanated from existing services.

The dilemma over what allocation strategy to choose may be termed policy stress, since neither strategy was strictly compatible with the other. In practice, the dilemma was resolved by using DF to remedy deficiencies since there was constant pressure from existing services for more resources, hence the phrase 'priorities by decibels'. Pressures to initiate a change of direction were not heard so loudly, or clearly, and usually came from outside the service. Policy stress could also occur when there existed two current policies which were not strictly compatible with one another. For example, to shift the emphasis towards community care was not compatible with the appointment of more consultants, if these were going to establish more firmly the institutional orientation of the service.
To sum up these reflections on the allocation of DF, existing allocations of revenue monies to services within Alpha and Beta were not disturbed or reviewed - the battles for resources occurred over DF since they represented the only free monies available for allocation. In the absence of an agreed approach to the problem of deciding priorities, the decisions made tended to reflect the current conventional wisdom about priorities generally within the NHS. These changed when national fashions and public opinion began to change, and the emphasis placed upon community health services in Alpha, and to a lesser extent in Beta, illustrated this process. In Alpha and Beta not much attention was given to the effectiveness of existing services, although there was much talk among administrators to the effect that this would now have to be done since the NHS was likely to be in a 'low-growth' situation for some time (a few expected a return to 'normalcy' within a year or so, and this, in their view, obviated the need for upheavals). Questions of priority were primarily dealt with by deciding whether more (and how much more) rather than less, of the current pattern of services should be provided in the future, or whether services should be maintained at current levels of provision (ie no change). None of this was surprising given the complexity of deciding priorities within health, and the reluctance to antagonise sections of the caring professions.

DF were needed in the majority of cases for 'first-aid', but sometimes they were committed to various projects
already in existence, or about to come into existence, like ordinary capital schemes involving running-costs which had to be met out of DF if the particular units were to come into operation. The alternative, which was to 'mothball' schemes, was not an attractive one. In the allocation process, pressure was also in the direction of bolstering up a service which was unsatisfactory; there was no attempt to focus upon any major programme, or area, of care, like child health, or care of the elderly, or care of the mentally ill. It came down, in the end, to a matter of fighting one's own corner to get resources in terms of inputs, that is, additional numbers of staff. This reflected the tremendous problems involved in devising acceptable measures of performance (ie outputs) upon which all those providing services can agree.

It is not being suggested here that the system was wrong in some way. In view of the constraints operating, and the coping strategies decision-makers adopted to manage the uncertainties of an environment which could change from one year to the next, as it did between Year 1 and Year 2, it might be that the processes observed were 'rational' (there are, as suggested in Chapter 4, multiple perceptions of rationality) in the sense that they were realistic and took account of the political nature of the environment where a number of professional groups were engaged in jostling for a 'slice of the cake'. Any other approach might have been totally unrealistic and impracticable and, therefore, unworkable. Commenting on the operation of the planning system adopted for the NHS in England, a report\(^3\) concluded:
At area and district where strategic planning confronted more immediate realities, rationality seemed less relevant and more tempered by other demands; for example, the upgrading of operating theatres despite a foreseen change of use of the hospital; and keeping an accident and emergency department open despite the continued running of another one nearby, were responses to more immediately felt wants.

Policy Triad
The concept, policy triad, was introduced in Chapter 1, and comprises the three groups of decision-makers, health board members, officers, professional and lay advisory bodies, involved in some degree in the allocation of DF. Not only were there inter-group tensions within the triad, but there were also intra-group pressures. One of the purposes of the case study was to discover whether all three elements of the triad had an equal influence on the allocation process, or whether particular groups exerted greater influence than others. From the description of each element of the triad (Chapters 7 to 9), as well as from the description of the allocation of DF (Chapters 11 and 12), it is quite clear that board members had a minimal impact on the decisions that emerged. This was consistent with most members' accounts of themselves and their role, and their general feelings of remoteness and impotence. Nevertheless, board members found themselves in a position to exert influence on the decision process if there were divisions within the AEG which prevented a consensus from being reached. When this happened, as it did in Alpha in Year 2 over nursing establishment levels, the matter in dispute had to be referred to the board for decision. In this particular instance, the board (through the PRC) decided in favour of
the CANO, thus rejecting the advice of the other members of the AEG. In the main, however, both AEGs presented united fronts to their respective boards.

The influence of the professional advisory structure on the allocation process was not striking but, as is argued below, perhaps there was no reason why it should have been, given that none of the allocation decisions showed significant departures from existing service provision. While there may have been grumbles from particular departments about not getting what they considered to be a fair share of available resources for staff, there was no radical policy shift envisaged which would have been likely to antagonise professional bodies and spur them into action. Overall, with the exception of a slight, and temporary, shift towards the community, allocation decisions conformed to traditional professional views about services, the ways in which these should be delivered, and the staffing levels required to deliver them to the desired standard. The influence of lay advisory bodies on the allocation process was practically non-existent during the observation period primarily because LHCs were in the process of being set up. However, from what evidence there was concerning the potential of these bodies, their impact on DF was likely to resemble that of board members.

This leaves the officers. Clearly, as shown by the description in Chapters 11 and 12, officers were the most active element of the triad involved in allocating DF and they dominated the scene. However, it would be a mistake
to equate high visibility and intense activity with influence and power. As officers' own assessment of the nature of the allocation exercise suggested, they were not so much in control of events as reacting to pressures as and when these surfaced. Officers, in other words, and recalling the distinction made in Chapter 8, and elsewhere, between the activities of management on the one hand and administration on the other, acted more like administrators than managers. The allocation process over the two years was ample testimony to the preoccupation with short-term pressures. There were the nursing staff crises in both boards, brought about by overspending (in some cases the result of commitments entered into by outgoing authorities at the time of reorganisation); then there were the constant demands for the relief of ever-increasing workloads and ever-lengthening waiting-lists. On top of this, officers were constrained by the sheer weight of existing services and the seemingly unstoppable momentum of inherited commitments, which severely constrained the scope for change.

In Chapter 1, in the section on an overview of the NHS, the medical profession's influence in health care was dealt with at some length. It is worth relating this discussion to what actually happened during the process of allocating DF in Alpha and Beta. The discussion in Chapter 1 considered the nature of the special relationship between doctors and the health service, a relationship captured by the term 'clinical autonomy'. While there was some direct evidence of clinical autonomy at work in Alpha and Beta
through, for example, attempts by officers to persuade doctors to review their clinical practices in an endeavour to use resources more effectively and more sparingly, by far the greatest impact of clinical autonomy on allocation decisions was covert and indirect, thus conforming to Lukes'\(^4\)' view of power whereby 'A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him by influence, shaping, or determining his very wants'. Power, as Lukes conceptualises it, does not show up in cases of actual conflict since it is aimed at preventing such conflict from arising in the first place. As long as the interests of those who set the policy agenda (ie the allocation of DF) are not threatened then a state of latent conflict may be said to exist. Thus the allocation of DF did not always reflect directly the wishes and wants of doctors; nor did it arise from some conspiracy on the part of the medical profession to win for itself the biggest share of available resources so depriving other groups in need of them. The process was altogether more subtle. The plain fact is that, in their present established position as leaders of the health care team and as the primary decision-makers, doctors' decisions to treat patients commit resources such as nurses, technicians, equipment and materials. In short, from the acts of the medical profession flows all else. Of course, once other groups like nurses, technicians and an array of support staff are established, they acquire a momentum of their own and impose additional pressures on administrators.
charged with allocating resources. But it is the needs of doctors, as initially defined by them, which trigger off the expansion of these other staff categories. Time and again in Alpha and Beta, the appointment of a consultant had a 'knock on' effect on other services. The medical profession may be said, then, to set the agenda of development fund allocations if only by their preventing, or hindering, by their very existence, the emergence of an alternative policy agenda.

Compounding these pressures is the ability of doctors to apply emotional pressure to win resources. Again, this does not have to occur in a crude, overt manner because when it comes to matters of life and death, it needs very little pressure to persuade most decision-makers of the 'benefits' to be derived from putting resources into life-saving ventures. While officers may hold private reservations about these allocations, they know that the weight of public opinion and media reaction would be likely quickly to reverse a decision that attempted to pursue a different course at the expense, say, of opening a new ward to reduce waiting-lists and ease pressures on existing staff and services. Considerations like these entered into Beta's decision to go ahead with an orthopaedic surgery unit in Year 2 despite the recommendations of the priorities memorandum aimed at shifting the emphasis in health policy from acute and maternity services to community services or those for the long-stay sick in hospital. The decision was also an illustration of the difficulties in switching resources
from inherited commitments (ie time lag).

It was suggested in Chapter 1 that it was over-simplistic to subscribe unerringly to the view that politics is about conflict and power. It has already been stated above that although power was at work in the allocation of DF, it did not involve conflict primarily because the very way in which the NHS is organised and operates, namely, as a set of arrangements conceived to provide a range of services to meet a range of 'needs' or demands, inevitably includes certain interests while excluding others. For example, a perspective emphasising health promotion inevitably merits a lower priority in a service organised round a medical, or disease, model of health which is centred on the interests of the medical profession and other health service groups.

Officers in charge of allocating DF may profess to be exercising power but the narrow range of choices open to them in deciding upon allocations reflects their recognition of what might happen if they attempted to enact dramatic policy shifts. An application of Lukes' concept of power reveals the sheer weight of the acute hospital sector which continues to absorb the bulk of available resources so preventing any lasting attempt so far to shift resources to other sectors. Once services, such as those comprising the acute sector, are established, organisational inertia sets in and the pressures to attend continually to existing services become overwhelming, as the views of decision-makers quoted in earlier chapters make abundantly clear. What officers are in involved in, then, is essentially a system
of **administrative politics** which includes discretionary decision-making within a narrowly prescribed range of options. All this occurs with the minimum of lay supervision since board members have only a peripheral role in development fund allocation decisions.

There are, Lukes is at pains to point out, methodological problems incurred in utilising his view of power. But, he concludes, 'it does not follow that, just because it is difficult or even impossible to show that power has been exercised in a given situation, we can conclude that it has not'. One way of approaching an analysis along these lines is to try to explain why things do not happen rather than why things do. The description of the allocation of DF has tried to do this through attempting to answer the question posed in Chapter 1 concerning the persistence of resource imbalances as between different sectors of health care, in particular those between acute services and the 'Cinderella' sectors. The case study tried to illuminate some of the reasons to account for this by focusing on the allocation of DF and by trying to discover the constraints operating on decision-makers which inhibited them from pursuing different policies. The chief constraint observed was the weight of existing services. These, more than anything else, accounted for the allocation patterns and routines which had been established in both boards. The services themselves, however, owed their existence to the presence and actions of professional groups, primarily the medical profession.

Politics, as noted in Chapter 1 and elsewhere, is not just
about power but also about puzzlement and uncertainty - 'men collectively wondering what to do'.(6) According to Heclo, 'the possession and relationships of power have not necessarily decided the substance of policy'.(7) Because decision-makers in Alpha and Beta were uncertain about the likely outcomes of policy shifts, it was much easier to play safe and maintain services along familiar lines. Despite the rhetorical stress on preventive health, and the alleged desirability of community services, which may have been substitutes for action, there was much ignorance as to what precisely was involved in terms of service impact on client-groups. One administrator,(8) for instance, has argued that evidence is lacking which would enable the efficacy of currently fashionable policy moves to be tested. The emphasis on primary care services, he suggests, 'is based more on an act of faith that (these) will be better and cheaper, than on hard evidence that they will be effective in ... reducing or alleviating ... morbidity'. There is an 'abysmal lack of answers' to the question of what is 'effective in therapy and prevention'. There are, in any case, no easy answers. Improved primary care services may ease the pressures on hospitals but then again they may lead to increased referrals. If one attempts to tackle the problem at the other end by improving the efficiency of resource use within hospitals there is a danger of 'heating up the system', as pointed out in Chapter 13. Speedier throughput per bed, for example, can lead to more GP referrals which, in turn, lead to increases in the workloads of hospital staff. Moreover, progress in these areas required
cooperation between health agencies and other bodies and, as has been pointed out, this was not much in evidence in Alpha and Beta. All of these factors served to reinforce a commitment to the status quo.

14.2 Conclusions (2) General Comment

In this section, an attempt is made to link the case study of development fund allocations to earlier discussions of the reorganised NHS and the introduction of a new management structure which was intended to bring about improvements in decision-making. Although the case study was concerned primarily with describing the decision-making process surrounding DF (the first of the study aims outlined in Chapter 1), a second aim was to present a profile of the reorganised NHS in Scotland by providing insights into the operation of the new management structure in two health boards. The descriptions of the policy triad, and of the allocation of DF, highlighted a number of tension points present in relationships among decision-makers, and in those between the various organisational levels within boards. The tension points, some of which coloured the allocation process, can be grouped under two broad categories: (a) the aims of reorganisation, and (b) the complexity of the management structure.

Under (a) above, two of the principal aims of reorganisation are:

(i) to improve efficiency and effectiveness through a better use of resources which, in turn, depends on improved management

(ii) to allow for a greater measure of participation by the providers and consumers
of health care in the decision-making process.

The question that needs to be posed in relation to these twin objectives is the extent to which they are compatible, or whether the achievement of one depends on the necessary failure, or distortion, of the other. Much of the tension sensed in relations between areas and districts in Alpha and Beta, and the large number of criticisms of, and frustrations with, the new system, stemmed from this dilemma and the inherent conflict to which it gave rise. Even in decisions on the allocation of DF, the need to consult widely was a constraint on the ability of Alpha and Beta to take speedy decisions. Moreover, the ambiguity between areas and districts over the appropriate level for the enactment of particular decisions with respect to DF caused some uncertainty which was never quite resolved.

As suggested in Chapter 8, the incompatibilities to which the two aims of reorganisation have given rise, stem from the mix of two management styles, the mechanistic and the organic, which do not blend well together. The mechanistic style is derived from rational notions of administration and decision-making, whereas the organic style owes more to notions of organisational pluralism. The attempt to reconcile the two conflicting styles arose from the need to appease all those interest groups intent on bettering their lot in the NHS following its reorganisation. With specific reference to this, Klein\(^{(9)}\) has written: 'If the reorganised NHS is over-complex, it is because when it came to the point ministers preferred to make political
concessions rather than stick single-mindedly to considerations of managerial efficiency'. Opposition from the caring professions was removed 'at the cost of entangling the new structure in a web of consultative committees'. What Klein does not consider is whether a structure geared to notions of managerial efficiency is appropriate for a service engaged in 'people work'. The very fact that such a structure has been subject to considerable distortion suggests that it is not. In other words, it is perhaps valid to view the managerial bias (which was essentially mechanistic) in the proposals for reorganisation as giving rise to inevitable distortions, given the nature of the health care environment, rather than begin from the standpoint that it is the so-called 'distortions' which have prevented the management style from being fully implemented. After all, the management style was responsible for the multi-tiered structure, and for trying to make effective an arbitrary division between the activities of policy and management, thus creating difficulties for lay board members and for the operation of areas and districts. Moreover, having committed themselves to management authorities, the architects of reorganisation had to allow consumers some say in the running of a service that was, after all, supposed to function in their interests. Hence the appearance of LHCs which gave rise to concern among board members who could not see room for both sets of bodies.

Whatever the origins of the complexity, there is no denying its existence, which is a major feature of the new service.
Under (b) above, i.e., the complexity of the management structure, the following tension points can be listed, all of which were observable in Alpha and Beta although they were not necessarily central to the allocation process in regard to DF. Rather, they seemed to permeate the structure as a whole within the two boards.

(i) The changed role of board members and officers, and the relationship between them.

In Chapter 3, it was pointed out that one of the most profound changes brought about by reorganisation was the creation of a system in which officers carrying major responsibilities are supervised by boards, instead of a system (as had operated prior to reorganisation) in which the concept is of boards assisted by officers. The great bulk of administrative and operational decisions are now left to officers, whether working in executive groups or individually. From the description, in Chapter 7, of board members, in Alpha primarily, few of them were clear about their role or, indeed, whether it added up to a role at all with any substance. Many members were unhappy to see large areas of decision-making removed from their purview under the rubric of 'delegation'. For their part, officers argued that reorganisation was merely making explicit what had happened implicitly under the former authorities and that, in any case, members were unable, by virtue of their position, to perform effectively. These tensions were, for the most part, latent, but were nevertheless real. They did not enter directly into the allocation of DF since this
was an area of decision-making from which members were largely excluded. Apart from being the practice in Alpha and Beta, it was also the practice in all but one of the boards which responded to the questionnaire. The allocation of DF was quite definitely an officer-dominated activity although, as has been suggested, one involving policy, as well as administrative, concerns.

(ii) The 'mismatch' between board members' prescribed role and their actual role performance.

The problems board members in Alpha and Beta experienced with their policy-making remit were explored in Chapter 7. Most members were unable to identify with, or find satisfaction in, their prescribed role. This led to many members operating in ways not intended and ones that brought them close to conflict with LHCs. Board members, in some cases, began to operate as former members of BoMs, becoming involved in day-to-day management issues. Visitation programmes served to encourage these members who, in any case, preferred to operate in this way. Understandably, in the circumstances, some members began to query the purpose and value of LHCs since they could see little difference between what they were doing and what the Councils were intended to do. Consequently, relations between the two sets of bodies were neither as close nor as cooperative as they might have been.

(iii) A more formal and tighter relationship between area officers and district officers (resulting from the line management structure) than that which operated between the former RHBs and BoMs.
As the description of officers' roles and functions in Chapter 8 revealed, there was a pull towards the centre in each of the two health boards because of their hierarchical structure. This could be a source of tension for those at lower management levels. The existence of districts, which has given rise to a structure with two tiers vying with each other for influence, has made conflict a clear possibility, whereas in a simpler structure, or one in which collateral (ie 'sideways' relationship) rather than superior-subordinate relationships prevailed, there might have been less opportunity for conflict to occur. Former RHBs and BoMs shared a close relationship but also a looser one which avoided the tensions that have emerged in the present structure. The process of allocating DF illustrated some of these tensions as they affected area-district relations, in particular the handling of savings by districts.

The rather woolly relationship between BoMs and RHBs was perhaps a sophisticated means of defusing what might easily have developed into an unworkable relationship. This is not to suggest that the relationship between areas and districts is becoming unworkable, but simply to point out that it has given rise to tensions for which there was less room in the previous structure. Although a BoM was responsible to a RHB, the relationship was not clear-cut, unlike the present relationship between areas and districts. The primary explanation for this difference lies in the fact that both BoMs and RHBs were boards of voluntary members.
possessing statutory powers. Where there are statutory authorities at both levels, the lines of responsibility can be somewhat blurred at the edges. The fact that there are now no statutory authorities at district level has created, without being over-dramatic, a 'crisis of identity' among district officers. This, as mentioned in Chapter 8, was reflected in Alpha and Beta through the device of bypassing, whereby heads of departments, and others, often preferred to go direct to area instead of referring matters to their district authorities. The lack of a statutory authority at district level was an important factor accounting for the low esteem in which districts generally were held. At area level, officers were still seen to be associated with the board and as deriving their authority from it. This had an important legitimising effect and assisted in making decisions appear 'acceptable' to those affected by them. No such relationship operated at district level. Moreover, some district officers bemoaned the lack of a statutory authority at that level which could perform the role of arbitrator in decision-making, in much the same way as the former BoMs had performed this function. As pointed out during the description of the allocation of DF, district officers who were members of DEGs, with the possible exception of the DFO, all had their own particular interests to protect which made the attainment of consensus difficult. The DA had a particularly sensitive dual role to perform: advocate and judge. At area level, matters could be referred to the board; but at district level, if agreement on an issue was not forthcoming, then there was
no alternative but to refer the matter to the AEG. This was not an attractive prospect to district officers who already felt in a vulnerable position without having to suffer the added indignity of being considered incompetent. While the prospect of referral to area might have served as a powerful inducement to reach agreement, this, it could be argued, is not necessarily the most appropriate way to arrive at the 'best' decisions.

(iv) The possibility of role conflict was inherent in the dual role of district officers; for example, in a particular situation, should they remain loyal to the DEG of which they were members, or to their area counterparts to whom they were directly accountable?

No instances of overt conflict were observed in Alpha and Beta although there were ample undertones to the effect that the area-district relationship was an awkward and, at times, uneasy one. For it to function effectively, the complex system of interlocking personal and corporate relationships requires to be finely balanced. In an uncertain, ever-changing environment, such as that which existed in Alpha and Beta with their ever-present pressure points and service deficiencies, achieving this fine balance is virtually an impossible task. In many ways, the relationship is too demanding of its operators, particularly in a service that is not governed by clear, measurable outputs, and measures of performance. To work effectively, districts have to have day-to-day management functions delegated to them; yet, at the same time, the line management relationship between individual officers and between exe-
cutive groups at area and district levels requires district officers to be monitored by their area counterparts. This delicate arrangement can easily slide into excessive interference by the area in the districts' sphere of responsibility. Yet, because district officers have their own sets of responsibilities and are not merely passive assistants to area officers, and because there is geographical separation between the two sets of officers, it is difficult for area officers to monitor district practices, in the event that they may have wished to do so. The description of the allocation process in regard to DF revealed some of these influences at play. For instance, in Alpha, in Year 1, the AEG was uncertain how to respond to the development lists submitted by the districts; it was unsure of the extent to which it should become involved in detailed consideration of particular requests and there were divisions over the appropriate stance that should be taken, with half the AEG taking one view of their role, and the other half taking an alternative view. At district level, there was a view that the chief function of officers at that level was to win as much resources for the district as possible, even if this meant bending the rules to their advantage. Despite the line management relationship, for many district officers the district unit came before any concern for the area unit, although, in theory, their loyalty was primarily to their area counterparts. Some of these tensions, which would probably have remained latent had resources been reasonably plentiful, manifested themselves over the issue of savings, and whether these should be used for district
priority developments, or be reported to the area for possible use elsewhere, according to the area's assessment of where the greatest need lay.

(v) The problem of maintaining a clear distinction between those issues an officer refers to his executive group, and those decisions he should take himself within his own responsibilities.

This tension did not arise specifically over the allocation of DF, but officers, in interviews, expressed that there were potential difficulties in always being able to draw a distinction between group concerns, and matters which should be reserved to individual officers. This dual personality, with which every AEG/DEG officer has to live, arises from the two sets of delegated powers. When meeting in a corporate capacity as an executive group, officers at area and district levels are able to take decisions on behalf of the board which exceeds the limits of their individual powers, and which, in the absence of an executive group system, would have had to be referred to the board. In addition, each officer has his own decision-making responsibilities in those areas affecting him. Quite apart from the difficulties in deciding which matters to refer to the executive group, and which to reserve for oneself, officers acting in their corporate capacity have to look at issues with a broader perspective than they are required to do when dealing with matters in their capacity as individual chief officers. As illustrated by the discussion in Chapter 8, at times this posed severe problems for decision-makers in Alpha and Beta.
One DFO in Alpha argued that anything with a financial implication should pass through the DEG. But even using this reasonably clear rule, there were grey areas which caused some tensions within the district. According to the DFO, 'we've had slight disagreements as to how far my administrative colleagues should go in deciding that something should be done 'without referring the matter to the DEG. But the DFO agreed that referral was not always feasible if action was quickly needed. For example, the DFO received a request from the DDO for a piece of equipment that had broken down and was irreparable.

It was going to cost £300 to £400. We'd used up all our non-recurring monies. I felt that this was a piece of equipment that he (ie the DDO) couldn't do without. I told him to go ahead and order a replacement. I'm bringing the matter up at the DEG so that they are aware of the situation. I don't think it's something we can hold back on. If one of my colleagues had done the same thing, I don't think I could object, particularly if it's something that is vital to the service.

However, it is precisely this kind of situation which can cause problems among officers, particularly when resources are scarce and there are many competing demands for these.

(vi) The view that sector administration (below districts) had been neglected and that it was created more as an after-thought than as an integral part of the management arrangements.

Again, this particular tension was not evident in the allocation of DF, although from interviews with officers, including sector administrators, it was quite clear that all was not well. There is no disputing the fact that very little thought had been given to sector administration, and
that this could only have had an unsettling effect on those who filled posts at this level. Moreover, because service providers found administration at sector level rather unsatisfactory this encouraged many of them to resort to bypassing. Dissatisfaction with administration at hospital/unit level permeated the structure. Generally, administrators were not held in high esteem by health care professionals.

(vii) Increased functionalism and specialisation among the providers of services.

A factor in the slow-down in decision-making is the increased emphasis on functional management within the NHS. At the same time, there has been increased specialisation within the health care professions, particularly the medical profession, which has further contributed to the cumbersome decision-making processes in existence. There is a very real tension inherent in current emphases on the health care teams, and on multi-disciplinary approaches to care issues, and the simultaneous emphasis on developments like the above that militate against a full realisation of the team concept. The unwieldy consultative machinery that exists within health boards is a direct consequence of increased professional specialisation and it can be seen as a surrogate for the failure of professionals to collaborate effectively. Functional management has also introduced distortions. For example, as the account of events in Year 2 in regard to savings made clear, the problems of how savings were to be used, and by whom, was considerably aggravated by the presence of functional
managers anxious to build up their own services. Certainly one DA was aware of the delicate nature of the dilemma and, while sympathising with the area's view, could understand the rationale behind the functional manager's approach to savings.

(viii) The relationship between doctors and administrators, through the advisory structure, but also generally. It was pointed out in the first section of this chapter that the influence of doctors did not directly enter into the development fund allocation process and had no cause to since it shaped the entire service. For all the criticisms levelled at administrators by doctors, in particular those arguments alleging their growing power and influence, administrators, overall, were rather weak - not necessarily individually, but collectively. Because of the NHS' split nature, a fundamental and continuing problem in the management of the service is the need to create, and maintain, a tolerable relationship between the administrative authorities and the doctors. The interests of the two groups, as earlier chapters have shown, could hardly be more divergent. Whereas the administrator is bound continually to keep in mind the general interests of the organisation, that is, the need to work within limits, to allocate resources fairly, to use them efficiently and effectively, to make the right choices among conflicting priorities, and the need to account for the expenditure of public funds, the doctor's objectives are quite different. They are centred on the needs of the patient, whatever these may be, and the doctor's
decisions are related to individual patients. In short, his primary loyalty is to his patients and not to the organisation. This is not to suggest that administrators never concern themselves with growth and expansion or that they do not, at times, have preferences for particular developments (it is clear from the case study that administrators at area and district levels identified with their respective local interests and were intent on furthering these as best they could); nor is it to suggest that doctors never concern themselves with wider organisational and policy matters, although there was little evidence of this in Alpha and Beta. But, overall, it seems likely that the conflicts and tensions between essentially administrative objectives and essentially professional objectives will always be characteristic of our system of health care, and it is, therefore, a matter of devising management arrangements which are able to recognise and provide for them. This, of course, is the raison d'être for the elaborate system of consultative committees at all levels of the NHS. But these, as has been seen, raise their own problems and, to some extent, reflect a failure of the professions to collaborate (see next section). Apart from the tensions outlined above which are found within health boards (from other evidence it is possible to conclude that they were not peculiar to Alpha and Beta), the other key tension point was not so much internal as external, that is, the relationship between health boards and the SHHD. It was suggested in the section on external constraints, that the relationship was an ambivalent one,
with centralising tendencies and decentralising ones taking place at the same time, as the boards and the Department strove to define an appropriate relationship. The relationship between centre and periphery would appear to be more flexible, and to contain fewer centralising elements, than the equivalent relationship in England. It is also fair to say that the relationship has not yet been fully defined - it is still evolving. In the specific area of development fund allocations, boards have substantial freedom to allocate these, subject, of course, to numerous constraints. While the SHHD must be included among these constraints, it was by no means an overriding one and its presence was felt mainly in Year 2 when the effects of national policies on boards could not be cushioned by a further allocation of funds during a period of severe resource constraint. In Year 1, the SHHD's impact on allocations was not significant.

In Chapter 1, it was stated that health authorities possessed a large measure of administrative influence over the services they provided, and that decision-making was to a large extent decentralised. The case study of the development fund allocation process has done nothing to dispel, or even to modify, this view. What needs to be emphasised, however, is the fact that although health boards possess a certain amount of autonomy from central control this does not necessarily mean that there are not other forces at work to erode this autonomy. Clearly, Alpha and Beta had more influence in theoretical terms than in practical terms.
For example, the SHHD includes the following statement in each of its annual reports: 'The deployment of revenue resources is largely determined by the decisions of individual health boards ...'. However, it is known from the description of what happened in Alpha and Beta that the only real freedom boards have in the allocation of resources derives from DF, the sums spent on existing services simply being maintained each year without any fundamental reviews taking place, despite the managerial rhetoric. But DF do not amount to vast amounts, and awkward decisions have to be taken since it is quite impossible to do everything. Administrators do not start with a 'clean slate', and, as the sections on constraints revealed in Chapter 13, there are many pressures operating on officers within boards which limit their autonomy and discretion. The legacy of the past is a more reliable predictor of the future than any circular to emerge from the SHHD exhorting boards to switch priorities. Moreover, relations with other agencies, like local authorities, were a vital factor in the allocation decisions reached by health boards.

The discussion of the allocation of DF was located against a background assumption that there was in existence (in theory, at any rate) a rational model of decision-making in the NHS. This rational model has not been plucked out of thin air. Reorganisation of the NHS in 1974 was concerned, to a very large extent, as earlier chapters have shown, with improving decision-making by streamlining the administrative structure and thus ensuring that decision-
making would become more efficient, more effective and more rational. There has never been any doubt that reorganisation was chiefly about management and how this might be improved, and, although Scotland did not move so vigorously in a managerial direction, there was an overspill of the 'managerial style' from the English Grey Book into the Scottish Health Service reorganisation. Moreover, the Farquharson-Lang report, which foreshadowed much of the management philosophy of the early 1970s, had some influence on the SHHD's thinking. Concepts like the separation of community representation from the management of health services, a key feature of the new structure, are congruent with this managerial style.

Recalling the discussion in Chapter 4, the term rationality has been used in the present context not merely to refer to a range of techniques and processes which have been advocated as being essential in any decision process. While these are important, and were a feature of the new arrangements with their emphasis on the management function and on the introduction of financial management skills in addition to basic accountancy skills, more important is the presupposition contained within a rational model that there exists a consensus within an organisation, among those involved in taking decisions. In other words, so the theory goes, decision-makers share a unitary view of organisational relationships and adhere to a belief that a common goal unites them all. Since the possibility of administrative and political complications fouling the smooth-running
machine is excluded, tensions, or conflicts of interest, which do arise are dismissed as irrational and are viewed as technical problems.

Perhaps the main conclusion to emerge from the case study, is how, in practice, in the setting of a particular process, namely, the allocation of DF, rationality is severely limited by the organisational and political environment which exists at health board level. The research has been an attempt to describe, and to understand, this environment by 'mapping' the encounters and the moves that took place over a two-year period in the allocation of DF.

From observations conducted within Alpha and Beta, as well as from data gathered by other means and from other sources, the theory of disjointed incrementalism has been put forward, with some important caveats, as an explanation of the decision process examined. Much of incremental theory is concerned with the severely limited capacity of individuals to comprehend the full complexities of organisational and budgetary life. Because a comprehensive grasp of it is intellectually impossible, the decision-maker has to simplify reality. While there is much truth in this account of incrementalism, it does not suffice as a full explanation of limited rationality. The implication is that incrementalism could be avoided, or reduced, if, for example, better information were available, or better communication was possible. But, as the analysis of the allocation process in Chapter 13 suggested, the problems associated with information (ie its availability, and its
adequacy) were political and/or organisational as well as technical. In short, they arose from the pluralistic environment which existed within Alpha and Beta, as distinct from a unitary one which is associated with rationality. Therefore, in any account of incrementalism, it is necessary to perceive resource-allocation decisions, or any decisions for that matter, as to some extent the outcome of clashes between entrenched interests. The clashes need not always actually occur; anticipation of them may be sufficient for decision-makers to attempt to avoid or minimise them (an example of latent conflict). The allocation strategy of fair shares was a means of defusing potential clashes of interest by appeasing these interests. Moreover, the commitment to existing services (ie the ratchet principle) which, above all, governed the flow of DF was a means of avoiding conflict while recognising, and accepting, the existence of powerful interests.

It should be stressed, therefore, that it was not solely cognitive deficiencies, or insufficient information, or some other technical problem, which accounted for an incremental approach to development fund allocations. While there was certainly puzzlement and uncertainty about the objectives the NHS ought to be pursuing and how progress might be made towards their achievement, these reflected political constraints and values rather than information problems. There were obvious political reasons, in the form of vested interests, which accounted for DF being allocated in ways that were 'irrational' if judged by the
rational model's criteria of a rational process of decision-making (ie a decision becomes more rational to the extent that an actor clarifies his goals or ends and examines the courses open to him within the conditions of the situation). In fact, the allocation processes pursued were 'rational' from the viewpoint of those making the decisions. Faced with constant pressures arising from existing services for more resources, there were strong, and convincing, reasons for operating at the margin but no further. Therefore, an account of incrementalism would be incomplete if it failed to capture the bargaining, the negotiating and the political nature of organisational phenomena. As the case study revealed, the decision process surrounding the allocation of DF was directly affected by the way in which the two health boards were run, that is, by their organisational arrangements, and by their day-to-day procedures and routines. For example, if there had been no districts, or if area-district relationships had been less fraught, within Alpha and Beta it might have been possible to make greater progress in the area of savings; at any rate, in a simpler structure, there would have been fewer obstacles to surmount. To take another example, the timetabling of the allocation process resulted in district officers having to allocate DF under pressure. Perhaps there would have been differences in the allocations made had the process been conducted at a less frantic pace. Of course, there is no way of knowing for certain; what is certain, however, is that factors like these were important in shaping the environment in which decision-makers operated and in which they allocated
DF. Other factors included the participants, the interactions between them, and the available information. All of these influences are worth bearing in mind when health service decisions are considered.

An account of incrementalism which attempts to include political and organisational factors can help to explain why some decisions are more, or less, incremental than others. The example cited in Chapter 13, where an attempt was made to alter the status quo in a somewhat less incremental fashion, was community care. The focus on the community health service in Alpha especially was the outcome of a political dialogue at local and national levels, and was not the outcome of some rational analysis. Policy-making is to some extent about fashions and fads, like the emphasis on management in the early 1970s which has now given way to a resurgence of politics (13) and while there were particular reasons for the emphasis on community care services, there seems little doubt that the national commitment to this policy option that emerged in the 1970s had much to do with what Schon (14) has referred to as 'the emergence of ideas in good currency'. He continues: 'underlying every public debate and every formal conflict over policy there is a barely visible process through which issues come to awareness and ideas about them become powerful'. Among the characteristic features of ideas in good currency are these: 'they change over time; they obey a law of limited numbers; and they lag behind changing events ...' (15) It was pointed out in Chapter 13 that
the attempt, which was only temporarily successful, to shift the emphasis in Alpha and Beta from hospital to community care, whatever the problems associated with such a move, was an example of innovation in an environment which was basically heavily committed to patching up the status quo. Innovation occurred not in any dramatic sense - there was no sharp break with precedent; but the decision to put more funds into community services was an example of a less incremental decision than others, and one which departed, albeit marginally, from the norm of 'more of the same', i.e. a policy of improvements and/or expansions. It has been suggested(16) that 'the difficulties of identifying and causing change are ... enormous' and that 'it takes particular pertinacity to work for large-scale changes which cannot become quickly visible and hence rewarding to those who have to defer present advantages for the sake of future gains'. Alpha and Beta were not exempt from these pressures.

14.3 Implications for Policy

Although this thesis has principally been about understanding, and not about reform, its value, apart from its illumination of a relatively unexplored area of decision-making, may lie in its implications for future developments within the NHS. It is appropriate, at this point, to recall the discussion in Chapter 4 on the use of paradigms, or competing frameworks, in social science research and the stories offered by each paradigm which can provide useful insights into processes. While the descriptions of the
actors involved in development fund allocations, and of the allocation process itself, may be likened to the telling of stories, the primary purpose of this storytelling has not been to offer policy advice. And yet, a researcher should not shirk his responsibilities by opting out of a commitment to relate his findings, however loosely, to wider policy concerns. It is just possible that if further organisational change in the NHS were to be contemplated, the insights provided by the present research could be useful. But a note of caution must be sounded. The ability to generalise with any certainty from one case study of one particular decision process, which has been observed in two health boards (out of fifteen), is extremely limited. Nevertheless, through a combination of data obtained from the case study, from the questionnaire circulated to the remaining health boards, and from numerous other sources to which a researcher has access when engaged in a research project, it is possible to go beyond the confines of the case study, and the data derived from it, and to link some of the themes to emerge from the research to future policy concerns. While the case study is probably unable, by itself, fully to support all the arguments which follow, sufficient evidence emerged from it to substantiate, to some degree, the points made about the limitations of structural change. Gouldner(17) has written:

It is not the sociologist's task to recommend alternative policies and to insist that some administrative options are 'better' than others. But if he is not a proper catalyst of social change, neither ought a sociologist to serve
as a justifier of received patterns, legitimating them with post factum omniscience as the product of 'inevitability'. If the sociologist may not expatiate upon what 'ought to be', he is still privileged to deal with another realm, 'the realm of what can be'.

A considerable part of this thesis has been taken up with drawing attention to the gap which exists between rational policy pronouncements, and the reality which exists in executing these pronouncements. Reorganisation of the NHS, based on a rational model of health service management and decision-making, is a classic example of this misconceived approach to social change. Following Wildavsky, what officials need are not injunctions to be rational but operational guides that will enable them to manage the requisite calculations. Commands like 'consider everything relevant' and 'base your decisions on complete understanding' are simply not helpful - they do not exclude anything and they do not point to operations that can be performed to arrive at a decision as do aids to calculation.

Through an attachment to the rational model, the fiction is maintained that decision-making is rational and that it occurs in accordance with a set of clear, objective, technical precepts. The reality, of course, is quite different and far less simple. Moreover, not only does **structural** change of the kind associated with massive re-organisations serve to disguise the real **processes** which operate, and to inhibit discussion of the methods actually used to allocate resources, it may even be counterproductive and make the attainment of desired goals more remote. This is because reorganisation **itself** involves costs. Hood has observed that
in the extreme case, reorganisation and ineffectiveness can become causally related: ineffectiveness causes demands for reorganisation, but reorganisational costs reduce effectiveness in the short term, which leads to demands for yet more reorganisation, and so on.

La Porte's views on the 'reorganisation complex' have already been mentioned in an earlier chapter. What was experienced over NHS reorganisation is symptomatic of modern political and social systems. According to La Porte, a characteristic response to public problems is to insist upon structural reorganisations designed to improve administrative performance. But in the process, a great many actions and policies intended to make a situation more manageable, that is, to reduce the uncertainty of a particular problem area, often work to increase the complexity of the institutions attempting to cope with the problem. Moreover, they may fail even to improve administrative performance and, in fact, change nothing of substance, in which case, reorganisation becomes little more than a form of 'tokenism', i.e. it becomes a symbolic response to change which is 'a symptom of the inability to achieve 'deep change'. This type of reorganisation is an attack on symptoms rather than causes. Mant likens the activity to 'a purification ritual', a 'clearing out of dead wood'.

Evidence suggests that organisations seem to be harder to change at the bottom than at the top, and in practice the field administrative structure may change less than a massive reorganisation might suggest. But if, as some
believe it is, the reorganisation complex is 'a substitute for making choices', (25) in this case in health policy, then it is not surprising that the emphasis should be on structure at the expense of process. Yet reorganisations of this type, as has just been mentioned, are not cost-free. For instance, and this seems to support La Porte's theory, reorganisation of the Scottish Health Service has, in many ways, increased the complexity of the organisational arrangements in ways which have had a rigidifying effect on decision-making, and which have reinforced the use of strategies aimed at attending to existing arrangements. In short, a state of policy stasis exists. Admittedly, shortage of funds flowing into the NHS has played its part in this state of affairs, but reorganisation, as has been pointed out on several occasions, was supposed to enable a different and better use to be made of existing resources. Moreover, the list of tension points cited earlier all owe their existence to reorganisation, and, while the former structure had imperfections, it does appear to have avoided some of the grosser distortions apparent in the new arrangements. Certainly board members had a clearer notion of their role and felt less remote in the former structure, and the fusion of the finance and administration functions at BoM level seemed to avoid some of the misunderstandings which have arisen under the present structure where, in the light of 'functional management' concepts, these functions have been separated. More important, perhaps, is the relationship between districts and areas which does seem to have an
excessive potential for conflict built into it. Although the RHB/BoM relationship may have been ill-defined, paradoxically, it was precisely this fuzziness that made the relationship a workable one. (26)

It could be argued that the 1974 structure is still new, that it needs more time to settle down and that the case study presented here has given a misleading picture. It is impossible to deny that the structure may improve with time, but it can also be argued convincingly that many of the tensions described in this thesis are structural in origin and will require to be removed, or, at any rate, ameliorated, through further structural change. Lest it be thought that the view being expressed here is completely anti-reorganisation, let some kind of balance be restored. Reorganisation has not been all bad, and the principle of integration, the cornerstone of the entire exercise, is a desirable one, as the lack of it was a major defect of the former structure. Moreover, reorganisation has transformed hospital administrators into health care administrators which has provided greater opportunities to plan and provide services on a wider basis than previously.

Structural change, however, can achieve only so much (which may, of course, be the intention, if it is a substitute for deep change), and perhaps the message to emerge most strongly from this research is that structural change leaves processes essentially as they were - unchanged. To the extent that reorganisation of the NHS was a re-jigging of administrative structures, and little else, attitudes
have remained basically unchanged. In short, for all the rhetoric, reorganisation has had a minimal impact on the cultural milieu of the NHS. The experience of CMSs is evidence of this; and, give or take minor inroads into this sensitive, and fiercely guarded, area of professional privilege, clinical autonomy continues to be asserted as fiercely as ever. Clearly, the architects of reorganisation refrained from looking to see what is done within the NHS, preferring, instead, to look at what should be done. Consequently, as Towell has observed,

left less than fully stated were the changes in power relationships required in order to achieve any radical impact on the prevailing distribution of resources, both between different types of health provision and between different parts of the country. This understatement has partly reflected the technocratic bias in much thinking about these issues: the tendency to assume that better techniques of analysis and management would in themselves suffice to accomplish such changes.

Organisational change, if it is to be introduced and managed successfully, probably needs to be incremental — although it is guided incrementalism, in the sense of there being a goal or set of goals, rather than disjointed incrementalism, in Braybrooke and Lindblom's secondary sense, that is involved. Planning and decision-making in the NHS, as in most organisations, are political processes; but this has been insufficiently emphasised. A report on the new management structure prepared for the Royal Commission on the NHS notes that 'the political aspect of planning was an example of the multiple perceptions of rationality which exist'. Practitioners and administrators, to cite two
collective groups of decision actors, both have different conceptions of what an ideal health service should be, and their differing views are not reconcilable through structural change alone. The report maintains that, in the end, 'planning statements come to represent the balance found between different concepts of rationality', and concludes that 'planning as a 'technology', a process of rationality, was not seen to have surmounted planning as an administrative or political exercise'.

Failure to view the NHS as a political system, that is, as a series of shifting coalitions of sectional groups, each with its own objectives, has led to a number of erroneous assumptions based on an image of the health service which stresses consensus and harmony. Concepts derived from scientific management were not so much determinants of the management model, which emerged in April 1974, as symptoms of a persistent belief in the unitary nature of organisational relationships in the NHS.

If an attempt is made to look at processes, and, in particular, at the decision-making process, and to acknowledge the presence of a political dimension, perhaps, over time, not by frontal assault, which would be short-lived in its consequences and achieve little, but by adaptation and adjustment from within of existing arrangements in the light of experience, it will be possible to arrive at better and more relevant structures which are congruent with these processes and which do not hinder and impede, but actually enable and facilitate, processes. It is
more than likely that 'undermining the foundations is just as effective a way of toppling a fortress as storming the ramparts'. (35) In line with this approach to change, the NHS will have to become a learning system, (36) rather than an authority structure; and the challenge over the coming years will be the evolution of such a system.

There are indications that the need 'to retain political realism' in decision processes is now being recognised. (37) This research suggests that there is a need to go more quickly in this direction. Faith in the rational model of decision-making is waning and, similarly, faith in macro-systems change imposed uniformly from the centre is less fashionable after the management traumas of recent years affecting almost all sections of the public sector. Massive reorganisations can appear ideal on paper - they are of limited usefulness when applied to the real world. If anything has been learned from reorganisation it has been its potential for creating the illusion of change, and for raising expectations which cannot be fulfilled. Realisable proposals for change, as has been argued, must start with the current system, since structural upheaval, as this research suggests, would once again be likely to leave processes undisturbed (as, indeed, appears to have happened after 1974, although it is perhaps too early to pass final judgement). A prerequisite is the need for a genuine commitment to change as distinct from an attachment to improved administrative machinery as a substitute for change. For this is a ploy which serves to distract atten-
tion only temporarily from the real policy dilemmas that have to be tackled, and from the inescapable political choices that have to be confronted. Of course, there are dilemmas in health service administration to which there are no final, once-and-for-all solutions. This case study, in a modest way, has pointed to some of these, including the dual nature of the NHS, with its professional component and its administrative component expressing the accountability downwards/accountability upwards dilemma. But, 'to know that there is no answer is itself an "answer" of sorts, if only as a discouragement to naive hopes'\(^{(38)}\)

And, once their existence has been recognised, inherent dualities and tensions can even be put to constructive use. Hopefully, this research has provided insights into, and has thus assisted in bringing about a greater understanding of, some of these dilemmas, and the nature of decision-making, generally, in local health authorities. Through understanding may emerge better informed policy initiatives.