Chapter 1

1. Confusion exists among social scientists as to whether decision-making and policy-making both have the same meaning, or whether there is a clear distinction between the two terms. For instance, Lowi, T., 'Decision-making vs. Policy-making: towards an antidote for technocracy', Public Administration Review, 30, No. 3, May/June 1970, pp. 314-325, objects to the two terms being used interchangeably, arguing that they have quite separate conceptual meanings. On the other hand, Brown, R. G. S., The Management of Welfare, Fontana, London, 1975, sees the two terms as being interrelated. He describes policy-making as a process of reaching strategic decisions which alter the character, volume, or distribution of the relevant services. Policy in the NHS is the outcome of participation with authorities and management teams. Brown's merging of the two terms is akin to the definition of decision-making adopted by Friend, J. K. and Jessop, W. N. in their study of decision-making in local government; see Local Government and Strategic Choice, second edition, Pergamon Press, Oxford, 1977. There is a close affinity between the two terms in those instances where strategic choices are being made. The case study is concerned with decisions which have a strategic impact in that they have a direct affect on the sorts of services provided by health boards. These decisions are examples of middle-range decision-making, ie decisions with policy implications. For further discussion of some of these semantical problems, see Heclo, H., Modern Social Politics in Britain and Sweden, Yale University Press, London, 1975, p. 4.

2. Ample evidence exists to support this conclusion. Since the inception of the NHS, general policy statements have been issued by the DHSS indicating that increasing priority will be given to services for the mentally handicapped and mentally ill. Yet, as Heller, T., Restructuring the Health Service, Croom Helm, London, 1978, among others, has pointed out, these priorities 'have never been translated into an increased proportion of the budget spent on these particular services' (p. 18). Townsend, P., 'Inequality in the Health Service', The Lancet, 15 June 1974, pp. 1179-89, has documented some costs relating to different services in different types of hospital. He concluded that not only is less money spent per patient on medical care in the non-acute hospitals (ie services for the long stay and chronic ill, mentally ill and mentally handicapped), less is also spent on food, cleaning and domestic services; see also Radical Statistics Health Group, In Defence of the NHS, London,
1977. The DHSS acknowledges the persistence of these imbalances between different services but how committed it is, or rather how much authority it actually possesses, to do something about resolving them remains unclear. In the DHSS's consultative document, Priorities for Health and Personal Social Services in England, HMSO, London, 1976, emphasis is placed on the elderly and on the handicapped, particularly the mentally disordered, as the client groups deserving of priority. A subsequent DHSS document, Priorities in the Health and Social Services: The Way Forward, HMSO, London, 1977, makes it clear that the main aim of health policy is 'to remedy past neglect of services, particularly those for the mentally ill and the mentally handicapped' (para. 1.14, p.6). However, there are more differences between these two priorities documents than similarities, and there is considerable scepticism concerning the DHSS's commitment to action. For instance, Brown, R G S., 'Accountability and control in the National Health Service', Health and Social Service Journal, 28 October 1977, Centre Eight Papers, pp. B9-B15, suggests that whereas the first priorities document 'gave a clear sense of direction about the need to alter priorities' within a given timescale, the later document 'was toned down from firm targets to hopeful aspirations' (p. B12). The Foreword of the later document makes it quite clear that 'significant and rapid changes in the desired directions (within the suggested time scale)' will not be possible (p. vii). The document proceeds to describe 'the general direction of service development... but not the pace of change' (para. 1.5, p. 2, emphasis added). Brown (ibid.) argues that 'the implications of the change from a prescriptive to a concessionary tone are clear enough', in particular the fact that what was proposed in the original document 'was not acceptable to the health authorities ...'. Furthermore, Brown, M., 'Priorities for health and personal social services', in Jones, K., ed., The Year Book of Social Policy in Britain 1976, Routledge and Kegan Paul, London, 1977, pp. 21-34, notes that 'expenditure on the mentally ill and handicapped... is actually projected to fall as a percentage of total expenditure' (p. 29). Having referred to the 'long history of fine policy statements in this area of service and an equally long history of slow progress in implementing them', she quotes the conclusion of another commentator on social service affairs who was convinced that 'progress would be faster if we concentrated less on the nature of the problems themselves, and more on the constraints which impede the introduction of reforms' (ibid., emphasis added). As subsequent sections of Chapter 1 aim to show, the case study is an attempt at providing some insights into what happens within health boards faced with these problems and constraints.

4. Levitt, R., The Reorganised National Health Service, Croom Helm, London, 1976 (revised 1977). This is a useful source book for factual information about the reorganised NHS and the period surrounding the reforms. It is in the tradition of much public administration writing in that it is not principally concerned with the dynamics of decision-making, dwelling instead on the institutional aspects of the new structure.

5. Ridley, op. cit., pp. 70-1.


15. Friend and Jessop, op. cit.


23. Illsley, R., 'Promotion to observer status', Social Science and Medicine, 9, 1975, pp. 63-67; a similar point is made in Donnison, et al, op. cit: 'Studies of administration tend to deal with the top or bottom levels of the structure: democratically elected bodies and their chief officers at one end: clients and those who serve them at the other. We neglect the levels between at our peril' (p.306).

The institute for Health Studies at Hull University has produced four reports based on research carried out into the activities of Hull Area Health Authority. The study traced the effects of reorganisation on authority members and officers. The reports are purely descriptive, having no theoretical foundations (not explicitly at any rate). However, they are of immense interest mainly because they represent the first study of its kind in the NHS at a local level. Many of the authors' findings are similar to those arising from the case study presented in Part 3; see Brown, R. G. S., Griffin, S. and Haywood, S. C., Humberside Reorganisation Project, 4 reports, Institute for Health Studies, University of Hull, 1973-75; see especially the final report, New Bottles: Old Wine?, September 1975. The contents of these reports have been condensed, modified and placed within a loose theoretical framework in Brown, R. G. S., Reorganising the National Health Service: A Case Study of Administrative Change, Blackwell/Robertson, Oxford, 1979.

There has been some controversy over the merits and/or demerits of examining resource allocation decisions in the public sector from a centralist or a localist perspective. Kogan, M. 'Notes and Comments', British Journal of Political Science, 6, 1976, pp. 507-508, is critical of those who focus on explanations which have a centralist bias since their work 'reflects too clearly the preoccupation of political scientists and policy analysts with the largest animals in the political science zoo'. He suggests that social policy analysts should begin to examine the 'vast web of institutions' which constitutes 'the sites of real social action' where 'money is spent, decisions are made, professionals exert power, (and) clientele receive services (or do not receive them)' (p. 508). In reply, Klein, R., ibid., p. 509, argues that 'it would surely be better to avoid drawing too sharp an antithesis between concentrating on macro-movements in public expenditure (my approach) and looking at
micro-decisions at the point of delivery (Kogan's approach). The two seem essentially complementary.


35. SHHD, Administrative Practice of Hospital Boards in Scotland (Farquharson-Lang), HMSO, Edinburgh, 1966.

36. See note 27 above.

37. See Chapter 3.

38. Watkin, B., 'Health care planning - comprehensive planning', Health and Social Service Journal, 20 September 1975, pp. 2097-8, and 'Health care planning - participation', Health and Social Service Journal, 27 September 1975, pp. 2169-70. In an attempt to remove some of the prevailing ignorance, the Royal Commission on the National Health Service commissioned a research team from Brunel University, under Professor Maurice Kogan, to study decision-making processes in the reorganised Service; see The working of the National Health Service, Research Paper Number 1, HMSO, London, 1978.


40. Ibid., p. 266.

41. See Chapter 2.

42. See, for example, Buxton, M. J. and Klein, R., 'Distribution of Hospital Provision: Policy Themes and Resource Variation', British Medical Journal, 8


47. See Klein, 'Policy-Making in the National Health Service', op. cit.


50. Wildavsky, op. cit.

51. ibid., p. 1.

52. ibid., p. v.

53. ibid., p. 5.

54. See Dearlove, op. cit.


57. See, for instance, Klein, R., 'Accountability in the NHS', Political Quarterly, 42, 1971, pp. 364-374;


61. ibid., p. 57.


63. SHHD, Organisation of Medical Work in the Hospital Service in Scotland (Brotherston) HMSO, Edinburgh, 1967.


65. See, for example, Martin, M., Colleagues or Competitors?, Occasional Papers on Social Administration No. 31, Bell, London, 1969; Armstrong, D., 'The Decline of the Medical Hegemony: A Review of Government Reports during the National Health Service', Social Science and Medicine, 10, No. 3/4 (March/April), 1976, pp. 157-163.

66. See Crossman, op. cit.


68. Armstrong, op. cit.

69. McKinsey and Company, Realizing the Promise of a National Health Service, submission by team from McKinsey led by Banham, J. to the Royal Commission on the NHS, January 1977, para. 3, p. 9. The team is at pains to point out that its views in no way represent McKinsey policy or views, and this is probably because the team
is critical of many aspects of the new management arrangements which McKinsey had a hand in devising.

70. ibid.

71. See Davies, C., 'Hospital Consultants and Collective Action', amended draft of a paper presented to the BSA Medical Sociology Conference, York, November 1973, unpublished.

72. See Chapter 9.


Chapter 2


2. Regional Chairmen's Enquiry into the working of the DHSS in relation to Regional Health Authorities, DHSS, London, May 1976. Dr David Owen (Minister of State for Health 1974-76) invited Regional Chairmen to examine the functions of the DHSS in its relationships with RHAs, and to recommend whether, in their view, economies of operation could be effected by means of a transfer and/or reduction in the scale of functions as between the Department and Regions.


5. Godber, op. cit., p. 79.


10. Ryan, op. cit.


12. ibid., p. 61.

13. In Scotland, if it materialises, devolution might lead to substantial changes in the structure of the NHS. See, for instance, the SNP's policy document, A Partnership in Health Care, SNP Health Policy Committee, November 1975; for reactions to these proposals see Drucker, H. M., 'Will politics wreck the health service in Scotland?', Health and Social Service Journal, 27 March 1976, pp. 588-589, British Medical Journal, 'Devolution', 8 May 1976, pp. 1127-1137. The British Medical Association in Scotland is opposed to devolution, a view shared by the Scottish Royal Colleges. For further discussion of the impact of devolution on the Scottish Health Service, see Chapter 3, section 3.4.

Changes in the organisation and management of the NHS might emerge from the recommendations of the Royal Commission on the NHS when it reports sometime in the summer 1979. The Commission was appointed in May 1976 in the midst of considerable unrest among service providers. Its terms of reference are: 'To consider in the interests both of the patients and of those who work in the NHS the best use and management of the financial and manpower resources of the NHS', The Royal Commission on the NHS, The Task of the Commission, HMSO, London, October 1976, para. 2, p.1. See also, Ryan, M., 'The Royal Commission on the NHS - Origins and Prospect', Social and Economic Administration, 11, No. 3, Autumn, 1977, pp. 194-205, who believes that the Commission will refrain from proposing radical changes which would involve further upheavals in the administrative structure. It will most likely lend
its support to measures already being examined by the DHSS with a view to improving the performance of the existing structure. A reform already being implemented is the merger of multi-district areas into single-district areas. For a comment on these changes, see Ball, D., 'A revolution on the quiet', Health and Social Service Journal, 3 March 1978, pp. 244-246.


16. See Chapters 3 and 8.


22. SHHD, Administrative Practice of Hospital Boards in Scotland (Farquharson-Lang), HMSO, Edinburgh, 1966.

23. ibid., para. 115(b), p. 35.

24. ibid., para. 212, p. 64. The creation of a chief executive post in the reorganised Scottish Health Service was rejected on the grounds that it would be a wholly unnatural concept. A former Principal Officer, Manpower Division, Common Services Agency (CSA), wrote that 'because of the multi-professional nature of the NHS, the decisions cannot be simplified to the extent that they can be taken by one individual who can over-ride the others if he thinks it necessary' (Moore, R.,
'Coordination', unpublished). See also, Hunter, T. D., 'Self-Run Hospitals', New Society, 14 October 1967. A chief executive type of management structure was also rejected as being inappropriate for England. The Grey Book (DHSS, Management Arrangements for the Reorganised NHS, HMSO, London, 1972, paras. 1.22 and 1.24, p. 15) states that the complexity of providing health care whereby 'different skills have to be combined in various ways ... , different professions must come together to plan and coordinate their activities, and the work of the various skill groups has to be coordinated within institutions' militates against 'organisation in a single hierarchy controlled by a chief executive ...'.

25. SHHD, op. cit., para. 316, p. 93.
26. ibid., para. 319, p. 94.
27. SHHD, Organisation of Medical Work in the Hospital Service in Scotland (Brotherston), HMSO, Edinburgh, 1967, para. 9, p. 11. Since the Brotherston report emphasised the need for integration within the Scottish Health Service, it is more than likely that Sir John Brotherston, Chief Medical Officer at the SHHD until 1977, had some influence on the shape taken by the re-organised structure. The medical profession as a whole is divided on the merits (and/or demerits) of reorganisation. From discussions with representatives of the profession, clinical and administrative, it would appear that doctors involved in management are sympathetic to the new organisation, whereas practising doctors are rather hostile towards it. Criticisms of the new structure are reviewed in Chapter 3.
31. See Chapter 3.
inquiry, of the Fulton report itself, and of criticisms of the report.


38. ibid., pp. 265-71.


41. Crossman, R. H. S., A Politician's View of Health Service Planning, University of Glasgow, 1972, p. 10.

42. ibid., p. 23.


45. Battistella and Chester, op. cit., p. 493.

47. ibid., p. 9.


49. See Chapter 3.


51. ibid., p. 6.


56. ibid., p. 1.


65. There has been criticism of the inadequacies of the 'do-it-yourself' approach to prevention. A number of government initiatives in the area of prevention have succumbed to this overly narrow conception of preventive health care. For example, the main theme of the DHSS's consultative document on prevention (see note 64 above) was that 'We as a society are becoming increasingly aware of how much depends on the attitude and actions of the individual about his health (p. 7, emphasis added). But as the Unit for the Study of Health Policy (USHP) has suggested, campaigns aimed at altering people's life-styles are doomed to failure if the underlying socio-economic environment, which to a large extent shapes these life-styles, is ignored. 'Economic progress as currently perceived can .... (foster) unhealthy dietary patterns and .... public choice is constrained because the public has no control over which foods and drinks will be pushed or neglected', USHP, Economic Policy and Health, London, November 1976, p. 3. Therefore, 'it is misleading to suggest that contemporary hazards to health are mainly a result of personal choices and that progress can be achieved by preaching sermons about responsibility' (USHP, 3-Year Review, April 1978, para. 9, p.11).


70. In an international context, growth of health care expenditure has been slower in the United Kingdom than elsewhere, in terms of share of GNP. For example, in
the United States national expenditure on health services in 1976 represented 8.5% of GNP, whereas in the UK the comparable figure was 5.4%. It has been estimated by McKinsey and Co. that on present trends, US expenditure could easily exceed 15% of GNP in 20 years' time. In their evidence to the Royal Commission on the NHS, a team of management consultants from McKinsey pointed out that 'there is ample evidence that, left to market forces, the cost of health care will escalate rapidly'. Realizing the Promise of a National Health Service, January 1977, para. 3, p. 1.5. The team concluded that the ability to control growth in expenditure in the UK is largely due to the existence in the NHS of a budgeting system in which expenditure levels are set in advance, and those working in the Service are expected to live within these limits. They pointed out also that the ability to control costs is a major concern of policy makers in the US, West Germany and Canada.


Chapter 3

1. DHSS, Management Arrangements for the Reorganised National Health Service, HMSO, London, 1972. In view of the contents of the 'Grey Book', with their emphasis on role clarity and precision, it is significant to note the managerial influences present in the drawing up of the arrangements. There were two important ones: Professor Elliott Jaques, Director of the Health Services Organisation Research Unit, Brunel University. For a discussion of Jaques' involvement in reorganisation see Jaques, E., ed., Health Services, Heinemann, London, 1978, especially pp. xvii-xviii. The book is an excellent insight into the Brunel approach to organisational problems; see also Rowbottom, R., et al, Hospital Organisation, Heinemann, London 1973. The second influence came in the shape of a team of management consultants from the McKinsey Corporation. It is difficult to judge the contributions that McKinsey made to the reorganisation since its advice was not published. However, it is perhaps significant that McKinsey has traditionally been oriented towards American industry rather than towards social services.

2. SHHD, Health Service Reorganisation Scotland, HSR (72) C1 - HSR (74) C12.


4. ibid., 'Foreword', p. 5. Battistella, R., and Chester, T. E., 'Reorganisation of the NHS: Background and Issues in England's Quest for a Comprehensive-Integ-
rated Planning and Delivery System', The Milbank Memorial Fund Quarterly (Health and Society), 51, No. 4, 1973, p. 518, suggest that the tendency for social workers to eschew identification with specialty areas like medical and psychiatric social work in favour of the 'generic' label, more prized for the career flexibility it provides and its symbolisation of professional autonomy and non-subservience to medical authority, has led to problems of cooperation between authorities. However, the desire for professional autonomy was a powerful motivating force insofar as social workers did not want to become integrated with the NHS. 'In justifying the policy of coordination in place of consolidation', argue the authors, 'both major political parties believe that the social services need a period of independence and special support to acquire strength and confidence; otherwise they will be swallowed up by the more powerful and prestigious health sector'.


7. For a good discussion of the arguments both for and against bringing the NHS under local government control, see Owen, D., A Unified Health Service, Pergamon Press, Oxford, 1968.

8. Unlike the NHS in England and Wales, no specific bodies were established to pursue collaboration between local and health authorities in the Scottish Health Service. Joint Consultative Committees (JCCs) were created in England and Wales but not in Scotland where the NHS (Scotland) Act 1972 simply states that health boards and local authorities are required to cooperate with one another. One reason for the different approach adopted by the three countries might be the different time-scale for local government reorganisation in Scotland which was one year behind England and Wales. See further Chapter 13, section 13.2.


11. SHHD, Doctors in an Integrated Health Service, HMSO,
Edinburgh, 1971. The report suggests strongly that 'it is in the interest of the health service that the professional knowledge and experience of all doctors should contribute to its management' (para. 14, p. 2).

12. SHHD, Reorganisation of the Scottish Health Services, op. cit., para. 11, p. 7.

13. DHSS, op. cit., para. 2.21, p. 24. There are mixed views among Scottish Health Service administrators over the advantages/disadvantages of a line management relationship between area officers and district officers. A review of the management of the reorganised NHS, undertaken by a working party of the Association of Chief Administrators of Health Authorities in December 1975, discovered no evidence of very strong advocacy for the area and district line relationship in Scotland, although some respondents supported it, saying that it ensured uniformity within the area, protected the smaller districts and might improve effectiveness. The report continued, 'Both Area and District Administrators mentioned difficulties resulting from the line relationship including the danger of the District's collective responsibilities being disrupted by an individual officer at Area level, of clinicians 'going to the top' and by-passing the District, of District officers needing to check with their superiors and report back and there were suggestions that this all caused delays' (section 7.3, para. 3, p. 36). See further Chapter 8, section 8.2, for evidence of such difficulties in the two health boards selected for study.


17. In England, the functions of the Scottish Health Service Planning Council are shared by the DHSS and the RHAs. The Planning Council is an example of the doctrine of 'hiving off' (as is the Common Services Agency) which became fashionable through Fulton. The intention is that the Council should be independent of the SHHD, although working closely with the Planning Unit of officials located within the Department. An analysis of these roles and relationships may be found in Institute for Operational Research Paper 883R, Programme of Studies in Health Planning, April 1974-May 1976, Edinburgh, 1976.


20. ibid., para. 5, p. 1.


30. ibid., para. 21, p. 6.

31. See Donald, B. L., 'Volunteers Retained as Managers: NHS Reorganisation Changes Authority Members' Role', Public Administration, 54, Autumn 1975, p. 303. See also Chapter 7 where this point is explored further.


33. See SHHD Circulars HSR (72) C3, p. 3 and HSR (73) C7.
34. SHHD Circular HSR (73) C7, p. 2.
35. SHHD Circular HSR (72) C3, p. 5.
36. NHS Circular 1975 (GEN) 54 (Scotland)
37. Institute of Health Service Administrators (IHSA), The Role of Unit and Sector Administrators in the National Health Service, report of a joint working party, London 1976, p. v.
38. ibid., para. 11.1, p. 5.
39. ibid., para. 11.4, p. 5.
41. IHSA, op. cit., para. 18.4, p. 17.
42. ibid., para. 11.16, p. 8.
43. SHHD, Reorganisation of the Scottish Health Services, op. cit., para. 55, p. 17.
44. SHHD Circular HSR (72) C3.
45. DHSS, Guide to Planning in the NHS, op. cit.
46. DHSS, Management Arrangements for the Reorganised National Health Service, op. cit., p. 10.
47. See note 13 above.
49. SHHD Circular HSR (72) C3.
50. I am indebted to Mr Robert Moore, former Principal Officer, Manpower Division, Common Services Agency, for providing me with some of the insights into the workings of the new management structure. Discussions with Mr Moore and a study of many of his unpublished papers on various aspects of reorganisation were a valuable source of information.
51. The recommendations of the Farquharson-Lang committee in 1966 were along very similar lines to those which emerged with reorganisation, but it is not possible to state to what extent the former RHBs had implemented the proposals contained in the Farquharson-Lang report.
However, it took reorganisation to introduce the necessary structural and organisational changes to facilitate the adoption of a management system which separated management from community representation and which attempted to give board members a more strategic policy-making role to perform. Nevertheless, Farquharson-Lang was a significant event as far as the Scottish Health Service is concerned since the report did create a climate in which the final reorganisation proposals evolved.


55. Quoted in ibid., p. 203.

56. SHHD Circular HSR (72) C3.

57. SHHD, Administrative Practice of Hospital Boards in Scotland, op. cit., para. 314, p. 93.

58. See further Chapter 7.


61. SHHD, Administrative Practice of Hospital Boards in Scotland, op. cit., p. 39.

62. See further Chapter 7.

63. See SHHD, 'The New Influences on Decision Making in the Reorganised Health Service', draft of a talk given by the Secretary to Health Services Conference, May 1973, unpublished.

64. See note 11 above. See also, SHHD, The Organisation of a Medical Advisory Structure, HMSO, Edinburgh 1973.

65. ibid., para. 3.4, p. 6.

66. ibid., para. 2.8, p. 4.
67. Battistella and Chester, op. cit.

68. See note 1 above.


70. ibid., p. 425.

71. See 'Editorial', The Hospital and Health Services Review, 67, No. 9, September 1971.


73. 'Editorial', The Hospital and Health Services Review, op. cit.

74. SHHD Circular HSR (73) C15.

75. 'Scottish objectives', The Hospital and Health Services Review, 69, July 1973, p. 240.

76. SHHD Circular HSR (73) C26, para. 2.

77. Brown, R. G. S., 'Reorganising the Health Service', op. cit.


79. ibid., p. 32.


87. Quoted in Hunter, 'Scots Wha Hae', op. cit.


89. ibid., p. 39.

90. ibid., pp. 39-44.

91. See further Chapter 7.


94. Labour Party plans involve the creation of 12 elected regional authorities (Regional Authorities and Local Government Reform, Transport House, London, July 1977). The NHS would come under the control of the new regions in one of three ways. The Conservative Party as such is not in favour of devolution to the English regions, although members of the party are. See, for example, Freeman, R., 'Devolution: what chance for England?', The Times, 14 October 1977, who is broadly in support of Labour Party proposals. Lord Hailsham is also in favour of some form of regionalism; see The Dilemma of Democracy, Collins, London 1978. The Liberals are firmly committed to federalism in the UK.

95. See Chapter 2, note 13.

96. For a different view of integration, see Stewart, J. D., 'The NHS - the structural problem', The Hospital and Health Services Review, 73, No. 9, September 1977, pp. 311-317. Stewart argues that integration of the health service is in fact 'divisory integration' (Derek Senior's term) because health authorities are structured to be different from the social services and education.

Chapter 4


5. See further Chapter 6.


7. ibid., p. 98.

8. ibid., p. 137.

9. Klein has drawn attention to the importance for studies of policy-making of the findings of social psychologists. See Klein, R., 'Policy Problems and Perceptions in the National Health Service', Policy and Politics, 2, No. 3, 1974, p. 229.


11. See further Chapter 6.


15. Bachrach and Baratz, op. cit.


17. Klein, R., in a review of Nicholson, M., The System,


19. ibid., p. 320.

20. ibid., p. 333.


23. ibid., p. 19. Barber, J. D., Power in Committees, Rand McNally and Co, Chicago, 1966, p. 5, argues that power is 'a topic of some interest and much frustrating complexity for political scientists'. Barber's study, which is of some relevance to the case study, analyses power in committees by examining the process of making a budget and by considering the values and perceptions which committee members bring to bear on decision-making. The case study presented in the present research is not about power as such. It is about decision-making and the calculations and strategies involved in allocating resources in a particular area of resource-allocation. However, it is not possible to examine who gets what and why without considering the power implications of these decisions. Apart from the possible exercise of power within a committee itself, power may also lie outside it but still have an impact on the decisions which are made (cf. Lukes, op. cit.).

Barber discusses the problems surrounding power analysis, including the dilemma of defining the term. He concludes that no single research project can span the entire range of possible definitions of power. The only way out of the confusion is to investigate those aspects considered to be significant, or possibly significant, in a particular research setting. For Barber, the focus of his power analysis was on the operative distribution of power - the practical relations of conflict and compromise - as seen through the eyes of the participants. This approach is in line with the phenomenological method which underlies the case study to some degree (see note 112 below). 'Power ... is contextual in character. It is not an isolated, temporary phenomenon abstracted from the flow of life ...' (Barber, op. cit., p. 47). Arguments about power are posed within a framework of concepts - time, knowledge, organisation and values. These concepts are elements of the framework which provides the present case study with its focus and means of structur-
ing the field to be observed. Therefore, power is studied in a political sense - it is shaped and distributed by participants in accordance with certain shared values and perceptions (ibid., p. 72). Barber maintains that the advantage of this method is that it gets at values and perceptions which are operative, in that they are linked by the respondents themselves to the practical problems and solutions which they develop.

25. ibid.
27. ibid.
29. ibid., p. 152.
30. See Chapter 1.
36. See Chapter 1.
38. See Chapter 3.
39. Self, op cit. Since the term 'complex' has become a much over-used word, particularly in these days of
rapid change, an explanation appears to be mandatory. La Porte, T., ed., Organised Social Complexity, Princeton University Press, New Jersey 1975, pp. 5-6, offers a suitable definition of complexity: 'systems that are characterised by organised complexity are those in which there is at least a moderate number of variables or parts related to each other in organic or interdependent ways'. La Porte's working definition of organised social complexity is: 'the degree of complexity of organised social systems is a function of the number of system components, the relative differentiation or variety of these components, and the degree of interdependence among these components'. It should be apparent from the discussion in Part 1 that this definition is applicable to the NHS.


42. ibid.

43. See Chapter 14.


47. ibid.

48. ibid.


50. ibid., p. 274.


52. Some observers have suggested that there has been a preoccupation with management techniques as reflected in the job specifications and training of Community Medicine Specialists. There have been criticisms of

53. See Chapter 2.


56. See Chapter 2.


58. ibid., pp. 98-9.

59. ibid., p. 102.


62. The attempt to procure savings in the two health boards was illustrative of the primary meaning of 'disjointed'; see further Chapters 12 to 14.


64. Allison, op. cit.


68. Allison, op. cit., claims that by treating organisations as political players, the Organisational Process Model and the Governmental Politics Model can be blended. This synthesis produces the Bureaucratic Politics Model.

69. Dimmock and Barnard, op. cit., p. 85.

70. ibid., p. 86.


73. Ball, op. cit.

74. Allison, op. cit.

75. Wildavsky, op. cit.

76. See Chapter 13.


78. Greenwood et al, op. cit.

79. ibid., p. 27.


81. ibid., p. 239.


83. The role of fashion in social policy-making should not be under-estimated. Higgins, J., The Poverty Business: Britain and America, Blackwell/Martin Robertson, London 1978, in her account of poverty policies over the last decade or so, draws attention to the importance of fashion in the adoption of a social engineering approach.
to change. Klein, R., 'Reorganisation: what went wrong', New Society, 22 September 1977, p. 593, notes that 'the intellectual fashions which led to the wave of reorganisation in the 1960s and 1970s have been displaced by a new set of fashions'. There is now less enthusiasm for social engineering and rational, synoptic solutions to social problems. There is, as Self (op. cit.) and others have noted, a resurgence of political as against administrative values. See also Schon, D., Beyond the Stable State, Penguin, Harmondsworth 1973, for a discussion of his notion of 'ideas in good currency', pp. 115ff.

84. Greenwood et al, op. cit., p. 27.
87. ibid., pp. 107-8.
89. Lukes, op. cit., pp. 24-5.
90. Cornford, op. cit., p. 239.
91. Klein, R., 'Policy-making in the National Health Service', Political Studies, 20, No. 1, 1974, pp. 1-14; also, by the same author, 'Policy Problems and Perceptions in the National Health Service', op. cit., pp. 219-236.
93. See Chapter 1, note 2.
96. See Chapters 1 and 14.
97. See Chapter 12.
99. ibid., p. 110.

100. ibid.

101. ibid., p. 111.

102. ibid., p. 112.

103. See Heclo, H. and Wildavsky, A., The Private Government of Public Money, Macmillan, London 1974, where the authors' observations of the Public Expenditure Survey Committee (PESC) tend to confirm the paradox between the employment of management techniques and their reinforcement, or encouragement, of incrementalism. 'PESC has enshrined incrementalism with a vengeance' (p. 238). 'Incrementalism has been reinforced through PESC by making each department more conscious of its own fair share of the total and more aware of other departments' departures from the expected rate of increase. In this sense, PESC has increased openness by reducing the scope for backstairs deals between Treasury and spending ministers. Vastly increasing a programme or switching priorities must be registered ... in the open' (p. 239). PESC has operated to make it 'more difficult to depart from the historical base' (p. 238).

104. See Chapters 13 and 14.

105. Allison, op. cit.


107. ibid.

108. Dror, op. cit.


112. A phenomenological perspective is one that 'reinstates human experience in its place as the primary datum about the world and it describes this experience by turning and returning to the intentional features of experience'; see Luckman, T., ed., Phenomenology and Sociology, Penguin, Harmondsworth 1978, p. 8. Carrier and Kendall, op. cit., argue that a phenomenological approach 'is based on the acceptance of the presence of "multiple realities"', therefore, 'an adequate account of policy development might be considered as one which presents as systematically as possible the participants' explanations of "why things
happened as they did" and "why certain decisions were taken" (p. 221).

113. Carrier and Kendall, op. cit.


116. ibid.

117. ibid., p. 261.

118. ibid., p. 77.

119. ibid.

120. ibid.

121. Schatzman and Strauss, op. cit.


123. Klein, 'Policy Problems and Perceptions in the National Health Service', op. cit.


Chapter 5


2. ibid.


5. Dye, op. cit.


10. ibid.

11. ibid., pp. 90 and 93.

12. ibid., p. 95.

13. ibid., p. 96.


15. ibid., p. 16.


19. ibid.


22. See Chapter 6.


27. ibid.

Chapter 6

1. The two health boards were chosen for their similari-
ties rather than for their differences; see section 6.2.

2. See further Chapter 10.

3. Reproduced at Appendix I.

4. But see discussion of structure in Chapter 14, section 14.3.

5. The Commission invited a team from Brunei University under Professor Maurice Kogan to study decision-making processes in the reorganised NHS; see Royal Commission on the National Health Service, *The Working of the National Health Service*, Research Paper Number 1, HMSO, London 1978. Brunei's involvement with this attempt at evaluating the new structure is somewhat ironical in view of its contribution to the original management arrangements adopted for the new structure; see Chapter 3, note 1. Just as concern over 'role uncertainty' and role confusion led to many of the concepts found in the Grey Book, it would seem that the structure devised to resolve these problems has failed to do so. Role uncertainty remains a feature of the NHS. According to the research team, this is partly the outcome of 'the over-elaborate organisation that has resulted'. Perhaps there is a connection between attempts at clarifying roles and relationships and the creation of cumbersome structures to cement these clarifications.


7. See section 6.3.

8. For details, see Chapter 12.


10. In the first circular describing the administrative structure of health boards, HSR (72) C3, CANO stood for Chief Administrative Nursing Officer. Subsequently, it became Chief Area Nursing Officer (HSR (73) C1). The reason for the change is not clear, but one explanation might be the reluctance of the nursing profession to emphasise its management function. There were already criticisms of nursing becoming over-managed as a result of the Salmon report (Ministry of Health and SHHD, *Report of the Committee on Senior Nursing Staff*, HMSO, London 1966).

11. See Chapter 8.

12. *ibid.*
15. A complete list of interviews is given at Appendix II.
16. Two examples appear at Appendix III.
17. See Chapters 12 and 13.
18. This is reproduced with covering letter at Appendix IV.
20. The research team worked within six geographical areas of England, Northern Ireland, Scotland and Wales. They studied one health board in Scotland.
21. See Appendix III for details.

Chapter 7

1. See, for example, Brown, R. G. S., 'Whose hand on the scalpel?', New Society, 6 September 1973, p. 575; Donald, B. L., 'Volunteers Retained as Managers: NHS Reorganisation Changes Authority Members' Role', Public Administration, 54, Autumn 1975, p. 313.
4. ibid., p. 122.
5. ibid.
6. See Chapter 3, including note 94.
7. Similar, but separate, documents were issued in England and in Wales.
9. ibid., para. 19, p. 5.
10. ibid.
11. ibid., para. 20, p. 6.


17. See also Chapter cit. 3.

18. SHHD, op. cit., para. 21, p. 6.


20. SHHD, The National Health Service and the Community in Scotland, op. cit., para. 12, p. 3.


22. A similar conclusion was reached in a report undertaken on behalf of the Royal Commission on the National Health Service, The working of the National Health Service, Research Paper Number 1, HMSO, London 1978, pp. 71-77.

23. SHHD Circular DS (73) 4.


27. ibid., p. 39.


29. See Appendix II for a listing of interviews with board members in Alpha and Beta.

30. See Appendix II for a listing of interviews with officers in Alpha and Beta.

31. 'The Role of a Health Board and its Members in its Area', unpublished paper delivered by Chairman of Alpha at St Andrews University, 1974, p. 2.

32. ibid.


34. See section 7.5.

35. For a stimulating analysis of the resistance to change exhibited by social systems, see Schon, D., Beyond the Stable State, Penguin, Harmondsworth 1973, especially Chapter 2.


37. ibid.


39. See Chapter 3 for a discussion of the terms 'policy' and 'administration'.

40. See Chapter 9, section 9.4 for an account of LHCs in Alpha and Beta.

41. Brown, 'Whose hand on the scalpel?', op. cit.

42. There have been no conferences since the intake of new board members in 1977. The conferences which were held were in connection specifically with the 1974 reorganisation. They have not been kept up partly on grounds of cost, and partly because there are doubts about their usefulness.

43. Heclo, op. cit., p. 186.

44. For further evidence of lay bias towards professional control in health boards, see Taylor, R., 'The local health system: observations on the exercise of professional influence', Health and Social Service Journal,
In late 1977, Beta's committee structure underwent changes in the size of membership and the remits of the two principal standing committees. The Personnel Committee (which replaced the Health and Personnel Committee) was to convene only as and when the convenor and Secretary of the board considered there was sufficient business to warrant holding a meeting. Furthermore, membership of the PRC was increased while the Personnel Committee had a smaller membership. The Health and Personnel Committee's terms of reference were adjusted to constitute the committee as a Personnel Committee only. It would appear that these changes were designed to overcome some of the problems highlighted in the description presented here.

In their study of Humberside AHA, Brown, R. G. S., et al, New Bottles: Old Wine? Institute for Health Studies, University of Hull, September 1975, note that at the close of each AHA meeting they attended 'there was also a "closed" committee session at the end of each main meeting to deal with personal matters ...' (p. 12; see also p. 34). However, the conduct of some business in private after a formal meeting is not the same as having a system of standing committees which deal with a great deal of business and which meet entirely in private. It would appear, then, that the system adopted by the AHAs in England is more open than the system operating in Scottish health boards. The Association of Chief Administrators of Health Authorities is quite justified in mentioning the openness of the English structure in its evidence to the Royal Commission on the NHS submitted in February 1977; see para. 6.4, p. 21.

Programme planning groups were not studied in Alpha and Beta since they were in the process of being set up.
Basically, the groups are involved in problem-solving from a multi-disciplinary perspective. The topics chosen have, in the main, been related to client groups like the elderly, the mentally ill or child health. In Beta, for example, it was decided that three programme planning groups should be set up in the following fields: mental disorder, child health and geriatrics. Initially, only one group on mental disorder was established. It was envisaged that a board member would be appointed to the group (and to each of the other two when they were established) and would be that group's chairman.

55. Haywood, 'More democracy for the NHS?', op. cit.
56. ibid.
57. ibid.
59. ibid., para. 74, p. 24.

Chapter 8

1. See Chapter 14 for a discussion of administering and maintaining an existing set of arrangements, activities which, it is argued here, differ from those associated with managing services.


3. ibid., p. 32.

4. ibid., p. 23.


8. SHHD Circular HSR (72) C3, para. 12, p. 3.

9. ibid., para. 11, p. 3.

11. ibid., p. 6.


13. SHHD Circular HSR (72) C3, para. 9, p. 2.

14. The new specialty of Community Medicine has come in for considerable criticism. See Chapter 4, note 52.

15. See SHHD, Doctors in an Integrated Health Service, HMSO, Edinburgh 1971, and The Organisation of a Medical Advisory Structure, HMSO, Edinburgh 1973. Both reports provide illustrations of the arguments raised in this section. For example in the first report, it is stated that 'a major problem which has faced the health service is how to create an effective partnership between the profession and the administration' (para. 131, p. 41). To bring about this partnership, the report stresses that a 'co-operative effort of all sections of the medical profession will be needed' (para. 175, p. 55). The theme of partnership is continued in the second report which states that 'if a change in medical thinking is needed, it is towards accepting as normal that the practice of medicine increasingly requires an organisational framework ....' (p. viii). The report acknowledges that 'clinicians are not by nature managers, managers are not doctors' but its aim is to heighten the professional awareness of both groups. For an excellent analysis of the reasons which make it very difficult for a partnership between the medical profession and managers to emerge, see Freidson, E., Professional Dominance, Atherton, New York 1970, and, by the same author, Profession of Medicine, Dodd, Mead and Co., New York, 1970.


17. Wright, M. S., 'Nurses as Managers', New Society, 19 September 1974, p. 740. Although nurses may now be
in a 'key position', reorganisation has done little to resolve the fundamental dilemma besetting nursing which, as Freidson argues (see references in note 15 above), is its subordination to medical authority. It is a problem facing all paraprofessionals in the medical division of labour. 'In a way unparalleled in any other industry, the physician controls and influences his field and all who venture near it' (quoted in Freidson, Profession of Medicine, op. cit., p. 48). Nurses have sought a way out of this dilemma by turning to administration. Freidson argues that nurses 'may be seen to be forsaking tasks distinctive to (them) in order to change (their) position in the paramedical division of labour. To escape subordination to medical authority, (they) must find some area of work over which (they) can claim and maintain a monopoly ...' (p. 66). Administration provides nurses with a professional career structure and is an attempt to solve the problem of blocked mobility arising from the medical profession's authority and autonomy (see Freidson, op. cit.).

19. See Chapter 12 for an illustration of this problem.
20. SHHD Circular HSR (72) C3, para. 22, pp. 4-5.
21. ibid., para. 14, p. 3.
22. 'Health Service Priorities: Bigotry or Balance?', paper by DMO (Beta), 1976, unpublished.
26. See Chapter 12 for reactions to the priorities memorandum in Alpha and Beta.
27. See Chapter 13, section 13.2, for a discussion of external and internal constraints.
29. This confusion in functions is illustrated by the case study; see Chapters 11 and 12.
30. SHHD Circular HSR (73) C7, para. 11a, p. 3.
31. ibid., para. 12, p. 3.


34. See Chapter 3.


40. *ibid.*, p. 76.

41. Chester, T. E. and Donald, B. L., 'Social change and NHS reorganisation', *The Hospital and Health Services Review*, 72, No. 6, 1976, p. 204.

42. SHHD Circular HSR (72) C3, paras. 27 and 28, pp. 5-6.

43. *ibid.*, para. 27, p. 5.

44. SHHD Circular HSR (73) C7, para. 4, p. 1.

45. NHS Circular No. 1975 (GEN) 54 (Scotland).


47. *ibid.*, pp. 154-163.


49. *ibid.*, p. 162.


51. See Chapter 1 for an elaboration of this point.

52. The Institute of Health Service Administrators, *The Role
The policy triad is explained in Chapter 1.

See Chapter 9 for a description of the advisory structures in Alpha and Beta.

See Chapter 14, section 14.2.

See Advisory, Conciliation and Arbitration Service (ACAS), Royal Commission on the National Health Service: ACAS Evidence, Report No. 12, London, May 1978, for a comment on the impact of reorganisation on industrial relations in the Health Service.


See Chapter 4 for a discussion of rationality and its usefulness in understanding decision-making.

Chapter 9

1. See Chapters 11 and 12 for evidence of this.


5. ibid.

6. ibid., para. 3.4, p. 6.

7. ibid., para. 5.5, p. 14.

8. See Appendix II for a listing of interviews with members of advisory committees in Alpha.

9. The nursing advisory structure in Scotland is under review.

11. See Freidson, E., Professional Dominance, Atherton, New York 1970. Freidson maintains that only medicine and dentistry may be regarded as truly professional because the medical profession, for instance, has the authority to direct and evaluate the work of others without being subject to formal direction and evaluation by them. Many groups claim the name profession but they do not possess the status, hence the term 'paraprofessional'. Etzioni, A., Modern Organisations, Prentice-Hall, New Jersey, 1964, pp. 87-9, employs the term 'semi-professional' in a similar sense. Semi-professionals possess less autonomy than professionals.


17. ibid., p. 286.


19. Ibid., p. 2.


25. Some recent developments may improve the standing and
performance of LHCs. For instance, the Association of Scottish LHCs was set up in 1977 on the initiative of councils themselves to provide a forum, at national level, for the exchange of views and information between councils. The inaugural conference was held in September 1977, and this will be an annual event. Not only is the Association aimed at assisting LHCs in the performance of their functions, but it is also aimed at expressing the views of LHCs on NHS matters where appropriate to the Secretary of State for Scotland and government departments. There is also a member of the Association on the Scottish Health Service Planning Council, and there is a possibility of LHC representatives becoming members of national programme planning groups.


Chapter 10

1. See further Chapters 11 and 12.

2. As noted in Chapter 1, similar myths about centralisation and the erosion of local autonomy surround the relationship between central and local government. The Layfield Committee on Local Government Finance supports the now fashionable view that local authorities are well along the road to becoming mere agents of central government. As an observer commissioned to submit work on central-local relations to the Committee argues, 'there is a clear orthodoxy of a local government system increasingly dependent on central government ...', Rhodes, R. A. W., 'Centre-Local Relations' in Appendix 6: The Relationship between Central and Local Government: Evidence and Commissioned Work, Report of the Committee of Inquiry into Local Government Finance (Layfield), Cmd. 6543, HMSO, London 1976, p. 177. Rhodes believes that the orthodox view of centre-local relations is misleading and that the reality is more complex and not simply a case of central control reigning supreme.

3. SHHD, Health Services in Scotland, Report for 1977,


6. SHHD, SHARE, op. cit., para. 2.2, p. 3.


9. See The Guardian, 7 September 1977 for a recent example. Money (about £5 million) allocated by the DHSS specifically to establish regional secure units in psychiatric hospitals was used by some RHAs 'to shore up their general revenue accounts and, in one case, to offset revenue overspending'. One MP requested an inquiry into the way in which 'money allocated nationally for a nationally-determined priority has been misapplied by these authorities'. The DHSS emphasised that 'although regions have been told to keep the special funds available to run secure units, there is no prohibition on their using the money for other purposes in the meantime'. It would require an Act of Parliament to enable the DHSS to ensure that health authorities spent the money according to its wishes and not according to the authorities' own priorities.

10. ibid.


16. ibid.


19. See Chapter 3.


22. The DHSS' Annual Report 1976, Cmdnd. 6931, HMSO, London 1977, notes that in March 1976, the Department made proposals for joint planning by AHAs and local authorities of priority services in which both have an interest. Under the joint financing scheme, specific sums are allocated to AHAs for capital and revenue expenditure. These are to be used, by agreement with the corresponding local authorities, on personal social services schemes important to both (see para. 9, p. 2). The initiative for joint planning came from a Central Policy Review Staff report, A Joint Framework for Social Policies, HMSO, London 1975. The report's central theme was the need to encourage corporate planning on an interagency basis as opposed to a system of fragmented departmentalism. This new approach was reflected in the consultative document issued by the DHSS, Priorities for Health and Personal Social Services in England, HMSO, London 1976. It marked a new departure since it was the first attempt to establish priorities throughout the health and personal social services. Final details of the new arrangements for joint planning were described in Circular HC (77) 17/ LAC (77) 10. The scheme is described briefly in the follow-up document to the 1976 consultative document on priorities, DHSS, The Way Forward, HMSO, London 1977, paras. 3.16 and 3.17, p. 26.

23. Watkin, op. cit.

24. See Chapter 3.

25. Watkin, op. cit.

Chapter 11

1. There was no ready explanation for this difference, other than the fact that, as noted in Chapter 8, district 'B' was of the opinion that its hospital services were substandard in comparison with those in district 'A'.

2. For a comment on programme planning groups, see Chapter 7, note 54.

3. This point is developed in Chapter 13, section 13.1.

4. See Chapter 13, section 13.5.

5. See Chapter 13, section 13.2.

6. This conclusion is supported by the discussion in Chapter 9.

7. The relationship was described in Chapter 8.

8. Work studies of nursing are fraught with difficulties. Inter-hospital variables are generally so great that the results of studies in one hospital are not transferable to another. Some studies of nurse staffing in hospitals have produced conflicting conclusions. For example, in measuring the quality of patient care and satisfaction, when more or less nursing hours were available, one study showed that decreasing nursing hours would lower the quality of nursing care; another study showed that increasing nursing hours did not increase patients' welfare; while a third study suggested that these studies could both be correct because patient satisfaction with nursing care increased when the hours of trained nursing staff were increased. Yet, some hospitals which had a lower proportion of trained nurses also provided adequate nursing care. Many factors influence the calculation of the nursing establishment, such as the fluctuation in workload, the equipment used and the design of the ward. Some of these problems were mentioned by the CANO in Alpha; see Chapter 12, section 12.2.

9. The three principal advisory committees (AMC, ANMC and APC) were approached. The AMC met before access could be negotiated, and the ANMC did not meet formally to discuss the proposals because they arrived too late for the Committee's April meeting. Members were contacted individually by the Committee's Chairman.

Chapter 12

1. This point is explored further in Chapter 13.


3. ibid., para. 11, p. 3.

4. ibid., para. 13, p. 4.

5. The argument over costs and savings in preventive medicine is a complex one. For instance, increasing expenditure on prevention tenfold will not lead to an equivalent saving on curative services. Indeed, it is likely to increase the demand on them. Effective prevention is likely only to delay expenditure. Therefore, investment in prevention cannot be justified on simple economic grounds despite the fact that many pronouncements on the subject emphasise this aspect. In the present example, fluoridation and preventive dentistry, such a policy would be likely to increase demand for conservative dentistry which would require an injection of resources.

6. This argument needs to be qualified. According to an editorial in The Hospital and Health Services Review, 72, No. 5, May 1976, pp. 147-8, 'It is more efficient to process patients more quickly but more intensive activity is also more expensive. If the result is more patients treated in the same beds rather than the same patients treated in fewer beds, costs will rise'. This is the inevitable outcome of the operation of supply and demand in health care and requires caution about the efficacy of day admissions, shorter treatment and so on.

7. According to Heller, T., Restructuring the Health Service, Croom Helm, London 1978, lack of appropriate data is hampering the tasks of those engaged in community medicine. He argues that 'the NHS collects information on the state of the service rather than on the illness behaviour or health of the community' (p.78).

8. SHHD, The Health Service in Scotland: The Way Ahead, HMSO, Edinburgh 1976. All the priorities documents, including The Way Ahead, have been criticised for (a) being rather weak in their statements of intent in re-dressing the imbalances within the NHS; and (b) for some of the value judgements which underlie their conclusions concerning the need to shift resources from the hospital service to the community care service. For example, certain assumptions about the advantages of community care are stated when there exists little data to support them. In para. 4.4, p. 16, in The Way Ahead, it is stated 'that Boards should continue to accord priority to the provision of health centres as the most effective means of promoting the develop-
ment of primary care'. There is no reference to the possible disadvantages of health centres, particularly their location and access. Much of what is said in the documents about the need for preventive health remains at the level of pure rhetoric. Heller notes that 'although Priorities for Health accepts that preventive efforts and health education should become part of the general work of all sections of the caring services, and in particular of the primary care service, the section on preventive health might easily be criticised as pure rhetoric in the absence of any real diversion of funds to this sector' (p. 97). For further criticisms of the English priorities document, see Whose Priorities?, Pamphlet 1, Radical Statistics Health Group, London 1976. See also Chapter 1, note 2.


10. ibid., para. 3.2, p. 12.


12. ibid., para. 4, p. 4.

13. See discussion of this relationship in Chapter 10; see also Chapter 13, section 13.2.

14. See notes 5 and 6 above.

15. In Grampian Health Board, the introduction of programme budgeting (PB) at the same time as the priorities memorandum appeared to give an added impetus to members' involvement in board affairs. For an account of PB see Mooney, G., 'Programme budgeting in an area health board', The Hospital and Health Services Review, 73, No. 11, November 1977, pp. 379-384. PB is a tool of policy-making and not a substitute for the exercise of judgement. At best, PB will better inform this judgement by presenting data in such a way that it is possible to identify trends in spending on particular programmes of care. In this way it can provide ammunition for those, like health authority members, who at present experience extreme difficulty in performing a useful role in planning services (see Chapter 7). PB at local level is developing rapidly in Scotland. In contrast, there has been little activity in England in this field (see Lee, K. and Mills, A., 'The contribution of economics to health service planning', Health and Social Service Journal, 8 February 1979, Centre Eight Papers, p. C38).


17. The report was the outcome of nearly 18 months' work. The feeling in Beta was that policies could not be
established in the absence of detailed knowledge of existing services in the area. A working party (10 members, half of whom were board members) was set up shortly after reorganisation with the following terms of reference: 'Report to the Board on the provision of existing resources and facilities within the area of (Beta) and as far as possible to assess the health needs of the population and determine objectives to meet these needs'.

Chapter 13


3. For instance, Klein, R., ed., Social Policy and Public Expenditure 1975: Inflation and Priorities, Centre for Studies in Social Policy/Macmillan, 1975, p. 89, argues that improving the NHS by adding to its manpower is only one possible policy option. Improving the use made of the NHS's manpower (while freezing or even reducing numbers) is another policy option. Klein suggests that more efficient use could be made of ancillary workers instead of constantly increasing their numbers. In the case of nursing and midwifery resources, Klein believes that their misallocation and maldistribution are more of a problem than shortages through failure to recruit or retain. Klein concedes, however, that it is the number of consultants which tends to determine the level of supporting staff needed and the demand for resources generated.


8. See Chapter 4 for a discussion of incrementalism.


12. See note 3 above.


21. See Chapter 11.

22. Klein, ed., *op. cit*.


25. See Chapter 11.
26. See Appendix IV, Question H.4.

27. ibid., Question H.5.


30. ibid., p. 12.

31. See Appendix IV, Question H.7.


35. ibid., p. 106.


Chapter 14


2. The priorities memorandum is to be followed up in 1979 with fresh guidelines for 1980-85 and beyond. Changes in the way DF are allocated may also result from the work of programme planning groups which is only just beginning to emerge.


5. ibid., p. 39.

7. ibid., p. 306.


15. ibid., p. 116.


19. For an account of these arising from NHS reorganisation, see Brown, R. G. S., et al, New Bottles: Old Wine?, Institute for Health Studies, University of Hull, 1975; see also, Brown, R. G. S., Reorganising the National Health Service: A Case Study of Administrative Change, Blackwell and Robertson, Oxford 1979, especially Chapter 10.


24. Hood, op. cit., p. 27.

25. ibid.


27. See report by the Unit for the Study of Health Policy, Re-thinking Community Medicine: Towards a Renaissance in Public Health? (forthcoming).


29. See discussion of incrementalism in Chapter 4.


34. See, for instance, The Outer Circle Policy Unit, A New Perspective on the National Health Service, London, December 1978. The report was written by the author with assistance from a multi-disciplinary working group and was submitted as evidence to the Royal Commission on the National Health Service. The main theme of the report is that structural change should succeed, rather than precede, process change and that the starting point should be the ethic of service to
the patient. This involves a reversal in current thinking about organisational issues in health care where the tendency has been to focus on structure and to push to the background the complex relations between individuals which make up the real operating system.


37. See Wiseman, C., 'Selection of Major Planning Issues', Policy Sciences, 9, 1978, pp. 71-86; see also Brown, Reorganising the National Health Service: ..., op.cit., Chapter 11.

APPENDIX I

RESEARCH PROJECT - STATEMENT OF INTENTIONS

1 THE RESEARCHER

I am a Postgraduate Research Student at Edinburgh University working towards a Ph D. I began this course, which takes three years, in October 1974. Before I embarked on it I studied Politics at Edinburgh University and, after four years, obtained a First Class Honours Degree (MA Soc Sci) in July 1974. Part of my undergraduate course work involved two dissertations on the NHS: one on the reorganisation and the new management structure, and the other on the uses and limitations of economic analysis in the NHS. My research is under the joint auspices of the Department of Social Administration and the Department of Politics, of the Faculty of Social Sciences, Edinburgh University. My supervisors are: Mrs Susan Sinclair (Senior Lecturer, Social Administration) and Mr Charles Raab (Lecturer, Politics). In order to obtain a Ph D I am required to plan, execute and write up, in the form of a thesis, a piece of original research.

2 STUDY OBJECTIVES

The broad aim of my research project is to examine how decisions are made in the NHS. I am approaching this subject by looking at one area of decision-making (the allocation of development funds) in two health boards in Scotland and then drawing some conclusions from my observations. I am interested in the process by which priorities are selected, the way in which the various groups involved in health care participate in decision-making, and the process by which a decision is finally reached. In so brief a note it is not possible to provide greater detail on the study objectives, although I should be most pleased to discuss these further with you.

3 METHOD OF WORK

I am adopting a Case Study approach which entails examining a particular area of decision-making in some depth. Three techniques are associated with this method: observation, interviews, documents. With your cooperation I would spend some time observing meetings relating to my project, although not without due regard to personal requirements for privacy. Apart from observing formal meetings and examining any existing documents, I would hope to have interviews (really conversations) with those involved in decisions relating to the allocation of development funds. It is not my intention that these interviews will 'make work' or otherwise complicate your normal routine.
4 CONFIDENTIALITY

I wish to assure you that I have no hidden intentions, such as an attempt to evaluate the work of your group; also to assure you that any future publication which may result from this study (ie Ph D thesis) will fully generalise the findings and mask the identities of persons for everyone's protection. All information and data gathered will be treated as confidential. Naturally I hope that you will find such a study to be of interest to you and in this way reciprocate your cooperation in the research project.

David J Hunter.
APPENDIX II

List of Interviews*

1 Health Boards (Alpha and Beta)**
   2 Chairmen
   2 Vice-Chairmen
   16 Members
   2 Secretaries***
   2 Treasurers***
   2 Chief Administrative Medical Officers
   2 Chief Area Nursing Officers
   1 Chief Administrative Dental Officer
   1 Chief Administrative Pharmaceutical Officer
   1 Area Personnel Officer
   4 District Administrators***
   3 District Finance Officers
   2 District Medical Officers
   2 District Nursing Officers
   1 District Management Accountant
   1 District Personnel Officer
   3 Sector Administrators
   3 Chairmen, professional advisory committees (AMC,ANMC,APC)
   1 Secretary, APC

2 Scottish Office/Scottish Home and Health Department
   1 Assistant Secretary, Scottish Office (Finance Division)
   1 Secretary, SHHD
   2 Undersecretaries, SHHD

3 Other
   1 Former Principal Officer, Manpower Division, Common Services Agency
   1 Former Treasurer, Grampian Health Board

* Only formal or semi-formal interviews have been listed. In addition, there were innumerable informal conversations both with those roles listed above and with others.

** Three members of Alpha declined to be interviewed because they had been newly appointed. A fourth member was absent during the interview period. Members of Beta were not interviewed for two reasons: (1) there was an access problem. The Secretary was reluctant to allow me to interview members at the time I had chosen to do so because the Secretary of State was about to announce membership changes for all boards. These
changes were in fact not announced for some months;
(2) it was apparent from informal discussions with a few of the members, and from other evidence, that Beta's members shared similar views to those held by members of Alpha. Nevertheless, interviews would have been conducted had it not been for the problems identified under (1) above.

*** Re-interviews were conducted with some, or all, of these roles.
Specimens of Aide Memoires for Interviews

A. Schedule for Board Members

1. Previous experience in NHS (before reorganisation).
2. Involvement in NHS since 1974.
3. Structure of health board:
   - frequency of board meetings and its standing committees
   - selection criteria for committee membership
   - preparation of agendas for meetings
   - are you satisfied with size of board: too big/small?
4. Functions:
   - board responsible for 'major policy, strategic planning decisions' and 'the broad allocation of resources'. What do you understand by these terms?
   - Would you say that this was an accurate definition of a member's role?
   - Do you think members can perform these tasks?
   - What does the performance of these tasks entail in practice?
   - Does the board participate in the formation of policy, or just in the ratification of policy, with the initiative for policy coming from the officers or elsewhere?
   - Do members feel sufficiently involved in decision-making?
   - With the board meeting in full only every ********, is this sufficient for members to be actively involved and knowledgeable about what is happening?
   - How much decision-making does the full board actually do - is most business carried out in the PRC?
   - Has one of the effects of having a PRC as the major committee of the board been to concentrate business in the hands of this committee and to limit discussion at full board meetings?
   - Is there sufficient time for discussion at meetings as a means of achieving a satisfying level of involvement by members?
   - Is there a feeling that the board is little more than a 'rubber-stamping' agency?
   - Do you think members find it difficult to see themselves as managers acting as individuals rather than as representatives of the community directly?
   - I've heard it said that in contrast to the old BoM structure, members don't feel happy with their new role. Is this true in your experience?
   - What preparations do new members have for their role? Is it a case of 'learning on the job'?
   - How much time on average do you devote to board matters?
   - Do members experience problems over access to information?
   - What sorts of information do members require to fulfil their functions? Is it forthcoming? Can members use it?
5. Relationships:
- Relationship between three groups of members: local authority members, professional members, lay members. Are there differences between these groups? Do professional members possess any advantages over other members in the way of expertise and greater knowledge of services?
- Relationship between members and officers. How dependent are members on officers? Do officers tend to push a particular proposal (or set of proposals) without giving options, or are problems clearly set out with alternative solutions/options presented?
- How much decision-making is the sole preserve of officers?
- Do members have any contact with district officers?
- Relationship between members and LHCs.

6. General:
- What particular duties does your role as ****** involve?
- Do you feel that the complexities of the NHS make it impossible for voluntary members to understand issues and how they can make an effective contribution?
- Do you think there's a problem between lay control and expert authority which makes some imbalance inevitable?
- Is a board necessary? Is there enough work for it to do?
- What changes, if any, would you like to see in the way the board operates?

B. Schedule for Area Officers*

1. Management Structure of Board:
- Composition, operation, aims
- Operation of AEG: departmental v. corporate outlook; consensus decision-making - how does this operate?
- Is there a preoccupation at area level with administration of services?
- Is there an explicit planning process - integrated strategy/policy guidelines - within which allocation decisions occur?
- To what extent does AEG react to, or anticipate, problems?
- Relationships between officers and board members - is board more than a 'rubber-stamping' agency? Is a board necessary?
- Relationship between boards and SHHD - what form does this take?
- Relationship between AEG and DEGs.

2. Budgeting System:
- Relationship between Secretary and Treasurer - division of functions between officers in regard to control of expenditure. Is separation of finance and
administration sensible: advantages and disadvantages?
- What problems and difficulties does the budgeting system give rise to?
- Does the budgeting system inhibit change?
- Because finance is split between revenue and capital, are physical planning changes easier to contemplate and implement than any attempts at modifying present patterns of care? Is there a way of getting a massive injection of revenue funds into, say, home nursing, community support, etc.?
- What are the problems associated with recurring and non-recurring funds?
- What are the problems arising from the carrying forward of unspent balances, or committing funds to expenditure low on list of priorities?
- Are tactics available to circumvent the anomalies of the budgeting system?
- Does the budgeting system foster an accounting outlook/bookkeeping mentality? Is there an emphasis on cost-control rather than on policy analysis or on the content of programmes and what they're supposed to achieve (ie outputs)?

3. Development Funds:
- Why are DF so important?
- If they enable a board to change direction, how is the direction chosen and how far can it move in the new direction?
- What can be done of significance with such small amounts?
- What is the scope for savings within existing allocations?
- What is the scope for redeploying existing resources? Is it possible to assess whether or not resources already committed to providing a service can be better spent? How would one go about such an exercise?
- Can sophisticated techniques or formulae be used to divide new monies more rationally, or with such small amounts is it not feasible or practicable?
- How do items get on the development lists - what process do they go through?
- What information and analysis are used in deciding what is important or not?
- How are choices made between, say, porters or medical secretaries, or between hospital nurses and community nurses? What criteria are employed?
- What are the factors and influences that make the AEG do something about one particular problem and not another, and make it do something at one point in time and not another?
- Are you happy with the way in which DF have been allocated this year? What changes, if any, would you like to see?
- Are you happy with the amount and type of information available to you to enable decisions on DF to be taken?
- How far should the AEG go in setting priorities and becoming involved in detailed choices between items on the lists?

4. Professions in Organisations:
- Does the special expertise and status of the medical profession and the concept of clinical autonomy give it more influence in decision-making than other groups?
- How are conflicts resolved between professional preferences and wider organisational ones?

* The schedule for district officers covered much of the same ground as was covered in interviews with area officers.

Note: The two specimen aide memoires above are broadly representative of the kinds of topics raised in interviews although the precise formulation of questions and their sequencing during an interview varied. Often it was not possible in the time available to cover all the areas at one interview, in which case a re-interview was fixed where possible.
Covering Letter and Questionnaire to Health Boards

**** ***** Esq
Secretary
***** Health Board
********

Dear Mr ********,

May I ask for your help in a piece of research I am conducting? I am a postgraduate research student at Edinburgh University, and I am carrying out some research on aspects of decision-making and resource-allocation in the NHS at Health Board level.

The research is an attempt to describe the resource-allocation process within Health Boards by focusing on the allocation of development funds of a recurring nature (ie staffing developments). It is concerned with discovering the process by which priorities are set, the way in which the various groups involved in health care participate in decision-making, and the process by which decisions on allocations are reached. Furthermore, the research is also intended as a profile of the reorganised NHS in Scotland. It is hoped that it will provide some insights into the operations of the new management structure within Health Boards. As the basis of this work, I spent almost two years observing the activities of 2 Health Boards.

I am writing to you and to other Health Board Secretaries in order to obtain data to supplement those I already have. I wish to ascertain whether my observations of the two Health Boards I selected are typical or atypical of certain decision-making and resource-allocation practices. To make sure that I obtain as much information as possible, I am anxious to receive a reply from each person I write to. I hope you will be willing to cooperate.

As you will see in the enclosed questionnaire, I require data of two types: facts and opinions. Much of the factual material, eg how often the Board meets, how many members there are, what standing committees have been established, etc., may be contained in a Handbook (if you produce one) for board members. Perhaps it would be possible for me to have a copy. This would prevent me from making unnecessary demands on your valuable time. In order to obtain other data (facts and opinions), you will find a list of questions enclosed with this letter. Would you be kind enough to complete the questionnaire as fully as possible and post it back to me (in London where I am now resident), using the reply-paid envelope?
I wish to assure you that I have no hidden intentions, such as an attempt to evaluate the work of your Board; also to assure you that any future publication which may result from my research (ie Ph.D. thesis) will fully generalise the findings and mask the identities of persons for everyone's protection. All information and data will be treated as confidential. The sole purpose of the questionnaire is to provide supplementary data which will lend weight to my own more detailed observations of two Health Boards.

Naturally I hope that you will find such a study to be of interest to you and in this way reciprocate your cooperation in the research project. I should be delighted to inform you of the results of my endeavours.

I hope that you will agree to help, and look forward to hearing from you at your earliest convenience, but preferably towards the beginning of March. If you wish further information about my research please contact me.

Yours sincerely,

David J Hunter
QUESTIONNAIRE

Please answer the following questions as fully as you can in the spaces provided.* If you wish, replies may be continued on separate sheets of paper.

A Health Board

A.1 How many board members do you have?  
(Please ignore if information is contained in Handbook)

A.2 How many board members are male, and how many are female?  
(Please ignore if information is contained in Handbook)

A.3 Can you give brief details of the occupation of each board member (for example, how many are local authority members, how many are clinicians, etc)? If retired, state former occupation if known.

A.4 What is the average age of board members?

A.5 To your knowledge, how many, if any, board members have had previous experience of NHS management prior to reorganisation (for example, as members of RHBs or BoMs)?

A.6 How often does the full Health Board meet?

A.7 Do the 4 chief officers (ie the AEG) attend every Health Board meeting? If not, what is the pattern of attendance?

A.8 Do District officers (ie the DEG) attend Health Board meetings? If so, who attends and is it on a regular basis or for particular purposes?

A.9 Do other chief officers (for example, the CADO) and/or other District officers (for example, the DDO) attend Health Board meetings? If so, is their attendance frequent, occasional or rare?

A.10 Do representatives from professional advisory committees attend Health Board meetings? If so, which committees are represented and is attendance frequent, occasional or rare?

A.11 Do representatives from LHCs attend Health Board meetings? If so, is attendance frequent, occasional or rare?

* Only the questions have been reproduced here. To save space, the spaces provided in the questionnaire for answers have been omitted.
A.12 Has the Health Board established standing committees? If so, how many are there and what functions do they perform?

A.13 How many board members sit on each committee?

A.14 On what criteria are members selected for particular Health Board committees?

A.15 How often do the various committees meet?

A.16 Apart from their Board and committee work, do board members perform other duties, for example, visiting hospitals/clinics, attending social events? If so, can you give details of visiting programmes and their operation?

A.17 Do board members (or some of them) have a special interest in particular areas of health care? If so, is this special interest encouraged/discouraged (please give reasons)?

B. Area Executive Group (AEG)

B.1 How often does the AEG meet?

B.2 Does the AEG operate under a permanent chairman? If so, on what grounds is he appointed/selected and for what duration?

B.3 Apart from the 4 members of the AEG, does any one else attend AEG meetings? If so, who, and for what purpose has he/she (have they) been invited to attend? Is their attendance frequent, occasional or rare?

B.4 Does the Chairman of the Board attend AEG meetings?

B.5 To whom are the AEG minutes circulated?

C. District Executive Group (DEG)

C.1 Is your Health Board a single-District area, a two-District area or a multi-District area?
Please answer the following question only if your Board is a single-District area:

C.2 What are the advantages/disadvantages of a single-District area?

Please answer the following questions only if your Board is a two-District area or a multi-District area:

C.3 What are the advantages/disadvantages of having Districts and/or of having a particular arrangement of Districts (for example, a two-District area, a multi-District area)?

C.4 How often do the DEGs meet?

C.5 Do the DEGs operate under permanent chairmen? If so, on what grounds are they appointed/selected and for what duration?

C.6 Apart from the 4 members of the DEG, does any one else attend DEG meetings? If so, who, and for what purposes has he/she (have they) been invited to attend? Is their attendance frequent, occasional or rare?

C.7 To whom are the DEG minutes circulated?

D Team Management

D.1 What do you understand by the term 'consensus management'?

D.2 Have you encountered any particular advantages/disadvantages with 'consensus management' (for example, does it slow down decision-making as has been alleged)? Please give details.

D.3 What contact is there between Area and District officers, and what form does this take (for example, are there meetings between executive groups and/or between individual officers)? Can you state approximately the frequency of these encounters, and for what purpose or which issues they occur?

D.4 Do you find a line management relationship between Area and District officers preferable to the system in
England, where there is no such relationship? Would you prefer to see the English arrangement operate in Scotland? Please state reasons for your preference.

E  Sector Administration

E.1 How many sectors is your Board divided into? Are the sectors organised geographically or functionally?

E.2 Does the arrangement of sectors pose particular advantages/disadvantages (for example, in terms of coordination and/or communication)?

E.3 What administrative arrangements exist at sector level between the sector administrator and the health care professions (for example, are multi-disciplinary teams in existence)?

F  Professional Advisory Committees

F.1 How often do the advisory committees meet?

F.2 Do the advisory committees operate independently of each other, or are there links between them (for example, exchanging of minutes)?

F.3 Can any conclusions be drawn about the value of these bodies?

G  Local Health Councils (LHCs)

G.1 How often do LHCs meet?

G.2 What contact is there between LHCs and the Board, i.e. with whom does a LHC have the most contact: sector administrators, District administrators, the Secretary, the Board?

G.3 Can any conclusions be drawn about the value of these bodies?

H  Development Funds
H.1 Why are development funds considered to be so vital?

H.2 How are the development lists (ie submissions for resources) compiled?

H.3 Can you list the stages through which development fund allocations pass before final decisions are taken? How long is the entire process?

H.4 What kinds of information are used in reaching development fund allocation decisions (for example, workloads, staffing norms, comparisons with other Boards, etc)? Is this kind of information sufficient in order to reach decisions? How important is it to argue a case persuasively, or to use judgement or hunch?

H.5 What bearing do the constraints of: (a) Time (b) Existing services (c) Projects/developments inherited from former authorities (RHBs, BoMs) (d) Lack of information (e) Consultation (f) Local Government services (g) Central guidance (SHHD circulars) (h) Other (please specify) have on decisions on development fund allocations?

H.6 Do you ever experience any conflict between expanding/improving existing services on the one hand, and moving in a new direction on the other (for example, starting a new service)? How are such conflicts, if they occur, resolved? Can you give details of any other conflicts (for example, spreading development funds thinly versus channelling the bulk of development funds to a particular development/project; or, the development of institutional services versus the development of community services)?

H.7 Do you find particular strategies useful to assist in the allocation of development funds? Examples of strategies might be: (a) fair shares: to allocate funds in such a way as to give everyone, or nearly everyone, something; (b) who will it hurt least? perhaps some group can do without an injection of funds;
(c) who has done all right so far? perhaps if a group has done particularly well on a previous occasion, they will receive less on the grounds that it is someone else's turn. (These are examples of possible strategies - please state whether these or other strategies influence the kinds of decisions reached).

H.8 At what stage, and to what extent, are board members involved in the development fund allocation process?

H.9 Are you satisfied with existing procedures for allocating development funds, or would you like to see changes made? If so, what might these be?

If you have other comments on the above, or related, topics, please write them below.
APPENDIX V

Abbreviations

ACAS  Advisory, Conciliation and Arbitration Service
AEG  Area Executive Group
AHA  Area Health Authority
AMC  Area Medical Committee
ANMC  Area Nursing and Midwifery Committee
APC  Area Paramedical Committee
ATO  Area Team of Officers
BoM  Board of Management
BMA  British Medical Association
BPM  Bureaucratic Politics Model
CFBP  Centrally Financed Building Programme
CPRS  Central Policy Review Staff
CADO  Chief Administrative Dental Officer
CAMO  Chief Administrative Medical Officer
CAPO  Chief Administrative Pharmaceutical Officer
CANO  Chief Area Nursing Officer
CNO  Chief Nursing Officer
CSA  Common Services Agency
CHC  Community Health Council
CMS  Community Medicine Specialist
DSA  Dental Surgery Assistant
DHSS  Department of Health and Social Security
DF  Development Funds
DA  District Administrator
DDO  District Dental Officer
DEG  District Executive Group
DFO  District Finance Officer
DMA  District Management Accountant
DMT  District Management Team
DMO  District Medical Officer
DNO  District Nursing Officer
DPO  District Personnel Officer
FPC  Family Practitioner Committee
GP   General Practitioner
GPM  Governmental Politics Model
GNP  Gross National Product
HMSO Her Majesty's Stationery Office
IHSA Institute of Health Service Administrators
IOR  Institute for Operational Research
ICCU Intensive Coronary Care Unit
JCC  Joint Consultative Committee
JLC  Joint Liaison Committee
LHC  Local Health Council
MbO Management by Objectives
MAS Medical Advisory Structure
MOH Medical Officer of Health
MD  Mentally Disordered
NHS National Health Service
OPM Organisational Process Model
PRC Policy and Resources Committee
PAR Programme Analysis and Review
PB  Programme Budgeting
PPBS Programme Planning Budgeting Systems
PESC Public Expenditure Survey Committee
RAM Rational Actor Model
RHA Regional Health Authority
<table>
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<tr>
<td>RHB</td>
<td>Regional Hospital Board</td>
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<tr>
<td>RAWP</td>
<td>Resource Allocation Working Party</td>
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<td>SHARE</td>
<td>Scottish Health Authorities Revenue Equalisation</td>
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<td>SHHD</td>
<td>Scottish Home and Health Department</td>
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<td>SHAS</td>
<td>Scottish Hospital Advisory Service</td>
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<tr>
<td>SHC</td>
<td>Scottish Hospital Costs</td>
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<tr>
<td>SNP</td>
<td>Scottish National Party</td>
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<tr>
<td>SAMO</td>
<td>Senior Administrative Medical Officer</td>
</tr>
<tr>
<td>SHO</td>
<td>Senior House Officer</td>
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<tr>
<td>SSRC</td>
<td>Social Science Research Council</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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