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Rathwell, Thomas Arnold

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THOMAS ARNOLD RATHWELL

Doctor of Philosophy

University of Durham

Department of Sociology and Social Policy

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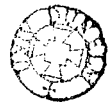

THE EFFECTS OF POLICY-MAKING WITHIN THE PLANNING FRAMEWORK FOR THE NATIONAL HEALTH SERVICE: THE RELATIONSHIP BETWEEN THEORY AND PRACTICE

TOM RATHWELL

ABSTRACT

The re-organisation of the National Health Service (NHS) in 1974 was intended to have a profound and fundamental effect upon the decision-making underpinning the development and delivery of health care services. Re-organisation was considered necessary on two grounds: first to unite the tripartite structure of health care which had existed since 1948; and second to instil the discipline of a corporate management and planning system into the health service.

By the late 1970s it had become clear that the corporate management planning system was not working; certainly not as its procreators had envisaged. The system was judged a failure on four counts:

1) health planning became largely prescriptive;
2) it remained essentially incrementalist;
3) very few plans and policies produced were evaluated; and
4) an inability to achieve the change envisaged.

Given the perceived failure of the corporate management planning system to effect change in the NHS, the study sought to investigate two pertinent issues: firstly, the extent to which the philosophy and rationale of health planning is a guiding force leading to better policies; and secondly, to understand those factors which influence and impinge on the planning process and the resulting policy decisions.

It is clear from the investigation that health planning in the NHS has failed to live up to expectations. The study has demonstrated that the introduction of a formal planning system into an organisation, however well-intended, is of itself not enough without additional and continuing support. In the local case study, mechanisms and procedures were established and adhered to, and yet very little in the way of acceptable and implementable plans were produced. Nevertheless policy changes did occur and a number of factors can be cited as explanation for this phenomenon.

Leadership emerged from the study as being a crucial ingredient in any recipe for planning and policy-making. Power was another dominant factor which was generally applied in a negative sense but when used in a positive way, dramatic results were possible. The third ingredient necessary for effective planning and policy-making was involvement not only of others in the organisation but also of the public. However having these attributes is not enough and the study has demonstrated the need for a more integrated style of planning, policy-making and management, and a concept of strategic management is proffered as an appropriate vehicle for creating within the NHS the desired future change consistent with the needs of the public.

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CHAPTER ONE

INTRODUCTION

The re-organisation of the British National Health Service (NHS) in 1974 was intended to have a profound and fundamental effect upon the decision-making underpinning the development and delivery of health care services. The key feature of the 1974 re-organisation was the introduction, for the first time in a British public agency, of a formal corporate management structure, whose principal characteristic was decision-making through consensus (DHSS, 1972). Re-organisation was considered necessary on two grounds. The first factor was the growing dissatisfaction with the tripartite structure of health care comprising general practitioner services, hospital and specialist care, and a mixture of community and personal support services, which had existed since 1948. The administrative distinctiveness of the three sectors was a recipe for fragmentation in that each sector was managed seperately, thus making "co-ordination of services and 'rational' planning very difficult" (Barnard, 1977, p.15).

The second thrust for change was partly a reflection of the growth of planning in general and health planning in particular, and partly the realization that in "modern technologically-based organisations too much is at stake to be left to chance" (Barnard, 1977, p.17). The very size and complexity of the NHS meant that it was virtually impossible for the centre, the Department of Health and Social Security (DHSS) - head office, to control in any meaningful way the overall development and directional growth of the NHS. Thus re-organisation had two principal objectives; to integrate under one

management structure the existing tripartite system; and to provide a mechanism whereby the DHSS could control the general direction and development of the NHS while allowing the local administrative units the necessary autonomy for operational decision-making. A formal corporate planning and management system was seen as essential if these two objectives were to be achieved (Barnard, 1977).

Corporate management planning systems are a means whereby organisations attempt to minimize uncertainty - to control the future - by developing a sophisticated information and communication network, incorporating key managers and interest groups, whose involvement was seen as instrumental in shaping the future direction of the organisation. Thus corporate planning was the vehicle through which decisions on policy were determined. The NHS was seen to be no different from other corporate entities and consequently a comprehensive and rational system of planning was introduced, on a national basis, shortly after the 1974 re-organisation (DHSS 1976a). The system was 'comprehensive' in that all levels in the administrative network, were involved in the process, all issues or topics were to be thoroughly assessed, a variety of courses of action could be identified and evaluated, so that the 'best' or most appropriate choice would emerge. In this context, 'rational' was taken to mean that all planning issues could be objectively evaluated, such that any decision made was done solely on the merits of the case.

Just as the corporate management structure was designed to bring some order to a fragmented NHS, so too the introduction of a formal planning system was intended to introduce some direction to the fragmented and chaotic planning of the 1950s and 1960s, to integrate and improve the delivery of services to patients and to ensure that those responsible for service provision were sensitized to the 'needs' of patients and the public. In summary, the NHS planning system had a dual purpose: firstly, as a vehicle through which changes could occur and secondly, as a mechanism for ensuring that the proposed changes were compatible with the perceived needs of the community (DHSS, 1972).

Unfulfilled Promises - a Rationale for Investigation

By the end of the 1970s it was abundantly clear that the NHS planning system was not working: certainly not as its procreators had envisaged (Royal Commission, 1979; DHSS, 1980a). Plans had been produced by health authorities in fulfillment of the formal requirements of the system as attested to by the mountain of planning documents to be seen in most health authorities. However, very few of these plans reflect the spirit of the planning system - to bring about change which is compatible to the needs of the community. Clearly the NHS planning system, and by implication corporate management, had not proved to be the appropriate instrument through which broad policy objectives were fashioned into workable and acceptable policies. Why should this be so?

The corporate planning and management model, according to Barnard (1977), was inappropriate for the NHS and therefore bound to fail. He

cites four reasons in support of his stance: no single product or range of products which would allow rationalization in the interest of efficiency; consumer behaviour which is difficult to understand; conflicting local interests which makes consultation and collaboration laborious; and, the dominant feature of health care delivery which concentrates on relieving present problems and not on the provision or attainment of a desirable state of affairs sometime in the future. Barnard offers no evidence in support of his claim that "these are potentially powerful factors against the substantial application of the corporate planning approach" [emphasis added] (1977, p. 18). It is the potentiality of these militating factors, among others, with which this research is concerned.

Attention is also directed to three additional major factors said to act as inhibitors which prevent the health planning process from reaching its full potential. These debilitating agents, so critics argue, are:

a) The prescriptive nature of the health services planning system itself which with its emphasis on an annual time scale precluded any detailed analysis and assessment of problems to such an extent that most plans tended to adopt DHSS guidelines as de facto appropriate levels of service (Barnard, et al, 1980a; 1980b).

b) Policy decision-making rooted very much in incrementalist philosophy had not given those involved in the planning of health services clear and succinct objectives within which to plan (Irving, et al, 1981; McNaught, 1981).

c) Satisfaction from most planners rested with the difficult enough task of producing the completed plan. No attempt was usually made to evaluate the policies arising out of the planning system in order to ascertain their impact upon the public nor indeed to see if the original policy objectives have been achieved (Barnard, et al, 1980a; 1980b).

d) The philosophy of planning has been allocated a relatively low profile while its practical elements have been emphasised to such an extent that planning had become a means unto itself rather than a pursuit of chosen policy objectives (Barnard, et al, 1979; Weller and Williams, 1982).

Purpose of the Study

The various critical assertions cited would seem to represent the current wisdom of self-critical NHS planners (Beveridge, 1983; Hunter, 1983:; Kearns, et al, 1983; Stevens and Whitt, 1983; Irving et al, 1981; McNaught, 1981). The purpose of the research was twofold: a) to determine how the philosophy and rational which underpins the NHS planning system is manifested in the plans produced, and b) to investigate the extent to which the assertions cited above influenced the planning process and the resulting policy decisions. An over-arching objective was to assess what impact the decisions emanating out of the central-local corporate framework of the NHS planning system had on the public for whom the service is designed. Critical to the assessment of the impact of decisions on the public and their responses to these decisions would be an analysis of the

role played by certain pressure groups (for instance, the Community Health Council [CHC]) in attempting to portray the public's interest in influencing policy decisions.

The Study Area

The application of health planning to the formulation of policy is considered through an empirical investigation of the processes involved in the consideration and development of services for two particular population groups, i) the elderly and ii) the mentally handicapped, in a single health authority. The choice of one health authority was deliberate, as was the choice of study groups. A single health authority was selected largely for logistical reasons. It was considered that to include more than one health authority would unduly complicate the investigation, especially in the light of the impending structural changes in the NHS.

At the time that the feasibility of the investigation was being discussed it became apparent that the Government was committed to the abolition of the Area tier in the management structure of the NHS (DHSS, 1980a). The Government's rationale for the removal of the Area tier was to strengthen local decision-making through the creation of local health authorities. Such an arrangement they believed would be more sensitive to the needs of the patient (DHSS, 1980a). Concomitant with this policy of strengthening and promoting local decision-making was the desire of the Government to devolve central functions, where appropriate, to the local level thereby fostering greater local accountability.

This change in 1982 in the management structure of the NHS was of profound significance for the investigation, because it was the Area tier which had had the major responsibility for planning and policy-making under the 1974 reorganisation. The abolition of the Area tier meant that planning and policy-making were devolved to the local level or District Health Authorities(DHA). This created difficulties for the research on two fronts: firstly, under the 1974 reorganisation responsibility for planning and policy-making was vested in the Area tier with the District tier responsible for the day to day operation of the health service. This meant that the Districts were only marginally involved in planning and policy-making so that when the Area tier was abolished there was no defined or developed planning capability within the Districts to enable them to carry on (Rathwell, 1982). Furthermore, the interregnum between the time it was known that the Area tier would go and the new DHAs were to come into power generally meant that any policy initiatives under discussion were suspended or put into abeyance because the one body did not necessarily wish to commit the other to a policy which they might not wish to support.

The second factor concerns policies already developed by the Area tier. There was no guarantee that policies and plans approved by the Area tier would be enthusiastically endorsed by the new DHAs. In fact there was some evidence to suggest that DHAs were most unlikely to accept the policy decision of their Area predecessors because one of the reasons for the demise of the Area was the continuing war of attrition between Areas and their Districts over policy issues (Royal Commission, 1979). The difference between them was largely one of

perspective: the Area level was concerned about the impact of policy issues across their territory - the area-wide view, whereas Districts were rightly troubled by the local implications. Thus it can be argued that even where DHAs shared the concern of the former Area level on a specific issue, they would probably prescribe a different recipe for consideration.

Fortunately not all former Area Health Authorities (AHA) had a number of health districts within their geographical boundaries. Some AHAs had none and were known as single district AHAs. It was decided that one of the single district AHAs would be the most appropriate focus for the study, since it was most likely that the constraints identified above would be either non-existent or greatly minimized. This decision would ensure that the then forthcoming structural changes in the NHS would not be very disruptive to the research protocol, since its outcome to a large extent depended upon the continuity of the decision-making and planning processes.

One such single district AHA was the Newcastle Health Authority (NHA) who agreed to participate in the research initiative. NHA very generously granted access to all its records including minutes of committee meetings and planning team meetings, general correspondence and published and unpublished reports.

The two study groups, the elderly and the mentally handicapped, were selected in consultation with officers from NHA. The intention was to select two population sub-groups about which considerable national policy existed, but in which there was clear local differentiation

with regard to the acceptance and implementation of the national guidance. Analysis has suggested that there is differentiation by health authorities between certain population sub-groups (Barnard, et al, 1979; Glennerster, et al, 1982; DHSS, 1976b; Rathwell, 1981).

In particular it would appear that contrary to central policy initiatives there is little evidence of a significant shift in resources from the hospital sector to the priority care groups identified by the DHSS (Glennerster, et al, 1983; Rathwell and Barnard, 1985). Where shifts in resources have occurred these have largely benefited the elderly, almost to the total exclusion of the other priorty groups (Rathwell and Barnard, 1985). In the planning and policy making arena the elderly are much more likely to be given differential even preferential treatment from which policy initiatives emerge than is generally the case for the mentally handicapped. Several reasons may be advanced for this view; firstly, the elderly have been and most likely will continue to be a topical issue, not least because of the latest demographic evidence, which indicates that the numbers of elderly are increasing absolutely and proportionally compared to the rest of the population (OPCS, 1985). Secondly, it is well-known that the elderly group are one of the major consumers of health services. This fact coupled with the forecast demographic changes for the elderly, is a powerful influence which most health authorities are unlikely to ignore. Thirdly, as the elderly have increased in number over the years so too has their influence in that, as a group they have become more adept and more astute at making their particular views known, which has had an obvious impact upon those agencies responsible for social welfare (Issacs and Robertson, 1985).

By contrast, the mentally handicapped possess little of these attributes and consequently it is easier for health policy-makers and implementers to ignore the needs of this particular group even where clear-cut national guidance exists (DHSS, 1971; National Development Group for the Mentally Handicapped, 1976; 1977; 1980; DHSS, 1980a). Compared to the elderly this group is numerically small, is perceived to have little or no clout - politically or socially, and most importantly is largely removed from public view, thanks mainly to the outmoded legacy of that Victorian institution, the asylum. The adage 'out of sight, out-of mind' was never more appropriate. Since they were numerically small and were currently being provided with reasonable services, NHS policy-makers did not share with the DHSS the same sense of urgency to institute reforms and/or inject more resources especially when viewed against all the other competing claims for additional resources facing each DHA. In light of the foregoing, it was considered that a examination of those two population sub-groups would provide a useful insight into how the planning process manages the development and implementation of specific policies.

The research therefore seeks to investigate two issues:

i) the extent to which the philosophy and rationale of health planning is a guiding force leading to better policies, and

ii) to understand those factors which influences and impinge on the planning process and the resulting policy decisions.

Understanding the planning process and discerning the factors which distinguish success from failure are not sufficient requisites for

change if such change only occurs on an ad hoc or infrequent basis. It is important, therefore, to not only direct, but also to sustain planning and policy-making through a mechanism or procedure which synthesizes the ingredients for success with sound management principles. In other words, the art of managing strategically.

Plan of Thesis

The thesis begins with a short but important Chapter (Two) which outlines the investigative framework applied in the research. Chapter Three goes on to provide the conceptual framework by considering, mainly from a review of the relevant literature, the theoretical background to decision-making in general and to planning and policy-making in particular. It does this from three separate but not mutually exclusive perspectives: theories of decision-making; questions of policy analysis; and social planning systems. This is the cornerstone of the thesis and is also its distinguishing feature; that is the synthesis of decision-making, policy analysis and planning systems within one conceptual framework as a basis for understanding the relationship between theory and practice of planning and policy-making in the NHS. The chapter also provides the background to the contextual discussion of the research findings because it places planning firmly within the decision-making sphere in the sense that plans are meaningless unless implemented. It is on this foundation which the remainder of the thesis is constructed.

Chapter Four traces the development of health planning in the NHS as background to Chapter Five which is an exposition of events as they unfolded in the study area and from which the observations crucial to

an understanding of the policy-making and planning processes have been drawn. Chapters Six to Nine embody the main discussion of the research with the topics or subjects in turn comprising: power and influence in decision-making; the political nature of planning and policy-making; professionals and the role of the planner; and public involvement in the planning process. Chapter Ten concludes by briefly rehearsing the original objectives of the research, how far those objectives have been achieved and discusses the concept of strategic management which has been put forward as an operative for synthesizing management principles with the key features identified with promoting and sustaining strategic change.

CHAPTER TWO

INVESTIGATIVE FRAMEWORK AND DISCUSSION AGENDA

The investigative framework employed in this study is that advocated by Barnard, et al (1980c) in Training Decisions in the NHS. The methodology which they recommend is one which attempts to pick up a policy issue in mid-stream and to retrospectively trace its origins through the organisation or agency's records while simultaneously following the policy issue through to its logical conclusion. The rationale for such a procedure is that it allows the researcher to analyse the way in which issues are screened or filtered at the outset; an important criterion when one is considering the policy-making process. It will also identify a number of clues which the researcher can draw on to help his/her understanding of the events that surround the current developments of the policy issue.

The success of such a methodology is very dependent upon the degree of co-operation and access to material granted by the agency or organisation under investigation. In the case of the research described herein, the researcher enjoyed the full co-operation of NHA. Being given unlimited access to material and making certain and specific deductions from the study thereof, provides only one aspect to the story. The researcher's observations need to be tested against the known facts, evidence from similar studies done elsewhere, and the views of those working within the study area. It is the third aspect, the corroboration of one's findings with those employed by the health authority, that is of concern here.

The analysis of the documentary evidence made available was supplemented through a series of interviews, or to be more precise, guided conversations, with a selection of the key actors involved in planning and decision-making in NHA. Time constraints did not allow all those involved in the planning process to be interviewed, so it was decided to focus on twelve persons who, from the analysis of the available documents, appeared to be instrumental in dictating the course of events. The key actors selected for interview were a fairly disparate group comprising clinicians, nurses, administrators, local government officers and lay persons. They were reasonably representative of the different professional and disciplinary groups involved in the planning process. Interviews took place with ten of the twelve persons chosen. One declined to be interviewed (a clinician) as that person has recently retired and therefore did not wish to participate on the grounds that they were no longer part of the Service. The other person (an administrator) has left the NHA for a post in a health authority in the South of England. It was not possible, because of time and resource constraints, to arrange to interview this person at their new workplace.

The loss of two persons from the original list of twelve was not thought to be damaging in terms of providing informed observations on the research findings. A majority of those interviewed had been involved in the planning machinery relevant to both groups, the elderly and the mentally handicapped, and were well-placed to be able to comment on the researcher's interpretation of the activities relating to them.

In an attempt to ensure that the responses of the interviewees were broadly comparable, a form of guided interview was used and a copy of the questions employed as an aide memoire during the course of the interview is affixed as an appendix. The interviews, which averaged between one and one and a half to two hours, were conducted at the interviewees place of work and the discussion was candid given the circumstances. In all cases the interview topics were discussed but not necessarily in the order listed in the appendix.

The purpose of the interviews was to elicit from these key actors their personal perceptions of how and why events appeared to unfold as they did. The results of the interviews largely confirmed the observations of the researcher but this was not consistently so. For instance, while a majority of those interviewed agreed with the researcher's interpretation as reflected in the interview questions and the ensuing discussion, they sought to add their own gloss on why events had proceeded in such a manner. In some cases a small minority, while not necessarily reflecting the researcher's reconstruction of events, indicated that they felt that possibly too much was being read into certain situations and suggested that nothing unusual or untoward had taken place. Despite their varying explanations, it was clear that a number of crucial factors, crucial in the sense that they appeared to be instrumental to the way events developed, do go a long way towards an elucidation and understanding of planning and policy-making in the NHS.

An Agenda for Discussion

A number of crucial features emerged both from the documentary evidence and the interview schedule which 'explain' why events progressed as they did. So it seems reasonable to hypothesize that they are central to the planning and policy-making arena, especially as some supporting evidence is available. The key characteristics of 'so-called' successful planning are; leadership, power, politics - particularly that related to existing provision of services, professional values and status, and the arrangements for and emphasis upon collaboration and consultation. Although each of these attributes will be considered in detail in later chapters, some justification of their importance as determining factors is necessary at this stage.

The chairperson of any group can be considered, de jure, to be the leader of the group and accordingly has the opportunity to play a central role vis-a-vis the group (Fiedler, 1967). This question of leadership and how it is exercised is closely related to the concept of power and how it is wielded. According to Lukes (1974) power can be applied in three ways: firstly, the so-called 'pluralists' approach (Ham and Hill, 1984) which is the conflict over what should be considered as key issues; secondly, non decision-making (Bachrach and Baratz, 1970) where specific issues are not included on the agenda because of their contentious nature; and thirdly, the shaping of events by suppressing known captious issues as well as those merely suspected as being so (Lukes, 1974). Clearly what is included on the agenda and how the discussion is transacted is crucial to the manner in which policies are agreed and implemented.

There appears to be in the NHS an unwritten law which says that existing services are largely sacrosanct, almost above scrutiny, even on grounds of effectiveness and efficiency. This means that existing or established services restrict the organisation's capability for planning because there is a tendency, as Barnard et al observed, to concentrate on issues which "do not immediately threaten to disrupt people's established patterns of behaviour" (1979, Vol. 4, p. 30). Thus it is argued that existing services and/or facilities act as an undue constraint upon the planning and policy-making process.

A central feature of the NHS is the clinical autonomy enjoyed by the medical profession which ensures that the clinical conditions are made available to practice medicine. An additional and related constraint is the general power and influence enjoyed by other health professionals over matters of policy. "They determine what shall be done and for whom" (Illich, 1978, p. 342). These factors can be a very formidable barrier to change; especially when the change being mooted appears to threaten widely held professional values and beliefs.

One of the major features of the 1974 reorganisation of the NHS was the desire to facilitate joint discussions between health authorities and local government. Legislation was enacted to ensure a closer working (that is, collaborative) relationship between both bodies. But requirements to work together does not necessarily guarantee success (Booth, 1981a; 1981b). Consultation was seen as being a key element of the NHS planning system, the purpose of which was to bring a degree of credibility and legitimacy to the planning process.

Regretably it failed to do either and has become largly discredited. This was because NHS planners and policy-makers saw it merely as a mechanism for information sharing whereas others, notably the CHC and certain professional groups saw things differently - an opportunity to contribute and potentially to influence the outcome of the planning system. Thus, to a certain extent consultation is the bete noire of NHS planners and policy-makers because it is something they are obliged to do but to which they carry very little commitment.

The foregoing has served as an appetiser to the contents and the issues to be discussed in the body of this research report. However before such a discussion can be undertaken, it is necessary to place the study within a conceptual framework and this is undertaken in Chapter Three.

CHAPTER THREE

HEALTH PLANNING AND POLICY-MAKING - A CONCEPTUAL FRAMEWORK

This chapter examines decision-making from two perspectives: its theoretical or conceptual roots; and, its practical manifestations. Decision-making as a concept and as an activity has been the subject of considerable attention by social and behavioural scientists who sought to understand the conditions or criteria necessary for decision-making. The logic underpinning an analysis of decision-making was simply this - if one understood the factors governing decision-making and how they impacted upon the process, then one could enhance the quality of decisions. There is an implicit but unstated assumption here; namely that because one does not understand the decision-making process any decisions reached, by definition, must be poor ones.

The problem with this relatively simplistic approach to decision-making is that decisions are very difficult to categorise: the issues they seek to remedy are in many cases exceedingly complex, and often involve a host or range of different groups or individuals who have their own specific and often unarticulated perception of what the problem is and how it should be solved. Such difficulties obviously complicate attempts to reach an understanding of decision-making and the development of a paradigm to 'explain' how it functions.

Commentators in order it seems to better understand the driving forces of decision-making sought to develop theories or models as

'explanation' for the way in which they believed decision-making functioned. A random selection of some of the literature on decision-making has highlighted an apparent paradox in this field of study; namely that while there are a variety of typologies or paradigms which purport to describe decision-making, there is an acknowledgement that in reality none of them do so satisfactorily (Klein, 1974a; 1974b; Rein, 1976). A brief forage among the many theories propounded on decision-making may be useful, if only to demonstrate the seeming lack of consensus on what decision-making is really about. As Harrison rightly notes, "the classification of theories . . . will always be problematic since many of the theories have several dimensions and it is not self-evident which ones should be used to structure the analysis" (1985, p. 106). The discussion of decision-making theories is followed by a brief forage into policy analysis as a framework within which decisions are located. The Chapter concludes with a general exploration of planning methodologies and attempts to place planning within a social context.

Towards Theories of Decision-Making

Attempts by various students of decision-making to categorise the different approaches which they have observed have yielded a variety of classifications. Pettigrew (1973) contends that decision-making theories can be split into two broad classes: the 'normative mathematical-economic' and the 'behavioural'. There appear to be two difficulties with Pettigrew's classification; firstly it is over-simplistic in that he presupposes that it is the behaviour of the organisation and those working within the organisation which largely determines decision outcomes. This seems to ignore the fact that

decisions occur within a political environment a fact which Pettigrew later acknowledges. Secondly, Pettigrew does not define nor does he discuss 'normative mathematical-economic' models thus depriving the reader of some insight into what these sorts of models might be. Thus one is left with Pettigrew's word that there are only two classes of decision-making theories but with no substantive argument in support of such a contention.

The two dimensional model for classifying theories of decision-making is the most common approach in the literature. Advocates of this method, Pettigrew apart, are Allen who sees decision theories as being either descriptive - details the process by which organisations "make decisions about what to do" (1979, p. 109), or normative - outlines a process by which organisations should make decisions. To a certain extent Allen's diagnosis at first glance appears to be very similar to that of Pettigrew but the reality is different. In Allen's terms normative models are in essence 'rational' models in that they can be used "to derive improvements in how decisions are actually made" (1979, p. 109). This classification of Allen's includes behavioural theories of decision-making which Pettigrew considered worthy of a separate categorisation. Thus definitional differences appear to be predominant in any attempt at classifying theories of decision-making. Allen does admit that such distinctions are rather artificial because the theoretical definitions are hardly if ever reflected in practice. Nevertheless such a handicap has not prevented him from analysing "decision-making by breaking down the process of decision-making into its component parts" (1975, p .109). Though the desire to compartmentalise decision-making seems inevitably to lead to confusion

as to what is what; the certainty is that the process of decision-making cannot be ignored.

The two dimensional model to explain, or at least analyse, why decisions are made as they are is also favoured by Ham and Hill (1984) and Hunter (1980). These authors share similar views on how one might classify theories of decision-making; specifically they argue that there are two separate but not mutually exclusive approaches to decision-making which can be stated as rational and incremental models. Rational models or theories presuppose that clear aims and objectives can be identified, that there are a variety of ways of achieving these, that their consequences are known, and thus the 'best' or most acceptable alternative can be readily identified and acted upon. In short, rational models by definition seek to be proactive. Incremental theories, by contrast, are politically driven in the sense that there is an unknown environment governing the manner in which decision-making occurs and which ultimately determines the decision outcome. In other words, the philosophy underpinning this approach is reactionary - wait for something to happen before deciding what to do about it.

The difficulty with a two-dimensional typology is that there are always some decisions that do not quite fit either, and this has led some scholars to argue that there are in essence three categories of decision-making. A main protagonist for a three category classification for decision-making theories was Allison (1969, 1971) who identified three divisions: rational policy model, organisational process model, and bureaucratic politics models. This three way

classification is endorsed by Rhodes who states that "although each of the models highlights certain features of the decision-making process, none is without its defects" (1979, p.32). A similar typology is used by Pfeffer (1982) although he employs different descriptive labels and attempts to minimise the models' inherent defects by arguing that their application is not universal because each model or theory operates somewhat differently depending on whether one is at the macro or micro level. At the macro level it is the behaviour of the organisation which is paramount, whereas at the micro level the focus is on groups, professions and/or individuals. The macro-micro dichotomization will be explored further later in the chapter when consideration is given to some approaches to the study of health policy.

There is a common theme beginning to appear through this assessment of various commentators' attempts to develop a classification of theories of decision-making: namely that similar labels are being encountered even if there is limited or no consensus about the elements to be found under each label. Despite this apparent difficulty in classifying theories of decision-making and recognising that no one system is ideal, the typology offered by Allison (figure 3.1) is a reasonable methodolgy because it seems to incorporate those elements which nearly all students of decision-making acknowledge as being of importance. Each of these three classifications, rational, organisational and political (incremental) will now be considered in turn.

FIGURE 3.1

Processes of Decision-Making

RATIONAL _____ ORGANISATIONAL _____ POLITICAL/

COMPREHENSIVE INCREMENTAL

Source: Allison, 1971; Rhodes, 1979.

The Rational Model

Rationality implies that decision-making can be considered as a logical and largely sequential process. It assumes that those making decisions have perfect (or near perfect) knowledge about what is occurring and how the issue arose, that all the options or courses of action can be considered, that each option or alternative can be evaluated as to its likely impact on the issue or problem under consideration, and that out of this procedure the optimal or best approach will emerge (Simon, 1957, Carley, 1980, Van de Ven, 1983). March offers a slightly different but nonetheless supportive definition of rationality to which he ascribed these characteristics.

1) a knowledge of alternatives - a set of options which are known and defined by the situation.
2) a knowledge of consequences - the impact of each alternative can be readily assessed.
3) a consistent preference ordering - the objective and values on which each option is evaluated are clearly specified.

4) a decision rule - all possibilities can be ranked in priority order according to a known and clearly defined set of criteria (1981, p. 210)

Carley suggests that rationality can be expressed in five sequential steps:

1) "A problem which requires action is identified and goals values and objectives related to the problems are classified and organised.
2) All important possible ways of solving the problem or achieving goals and objectives are listed - these are alternative strategies, courses of action, or policies.
3) The important consequences which would follow from each alternative strategy are predicted and the probability of those consequences occurring is estimated.
4) The consequences of each strategy are then compared to the goals and objectives identified above.
5) Finally, a policy or strategy is selected in which consequences most closely match goals and objectives, or the problem is most nearly solved, or most benefit is got from equal cost or equal benefit at least cost" (1980, p. 11).

In essence the pattern of activities which March and Carley ascribe to rational decision-making are very similar if not identical. Nonetheless, the process of rationality described above is but an ideal or model and as such is "an abstraction from reality that is intended to order and simplify our view of that reality while still

capturing its essential characteristics" (Forcese and Richer, quoted in Carley, 1980, p. 11).

Critics of the rational model argue that decisions seldom occur in a rational manner as organisations are not homogeneous - they are a composite of groups (Simon, 1957, Rhodes, 1979; Ham and Hill 1984). Another criticism of the rational approach is that, by definition, it demands comprehensiveness. Lindblom rails against the notion of comprehensiveness because "a concept of rationality appropriate for judging a complex political system cannot be defined" (1968, p. 10). In essence what these and other critics are saying is that the rational model is inherently sterile because "the limits of human cognition and perception coupled with problems of conflicting ends in collective decision-making severely restrict the relevance of the rational model" (Van de Ven, 1983, p. 41).

Carley suggests that the rational model has a third weakness; namely that it assumes that "it is possible to develop a social welfare function" which he defines as "a preference ranking by society on some set of alternative strategies" (1980, p. 16). Although Carley goes on to discuss the difficulties inherent in the social welfare function they can be largely categorised as: no consistent or agreed views as to which policy or programme is 'best for society'; the benefits of a set of actions may not be universally distributed amongst society in the sense that some may benefit at the expense of others; and, society is not homogeneous but composed of a heterogeneous mix who possess different values and objectives and have different perceptions of what is 'best' for society. In the end, Carley argues that while

the development of the social welfare function is not all that critical, it is necessary for governments to have "a series of 'working' social welfare functions upon which to base policy" (1980, p. 18).

Inspite of its limitations, Carley is relatively sympathetic towards rational decision-making since he argues that "the rational model is a valuable but partial perspective on policy problems" (1980, p. 11). This view of 'limited rationality' is one which is shared by a number of writers: notably Allison (1969;1971) who argues that the assumption of limited rationality is both a common and acceptable one; Etzioni (1967) who sees rationality not as an achievable ideal but one that is worth approaching; and Rawls who refers instead to "deliberate rationality", a concept which suggests that "we should deliberate up to the point where the likely benefits from improving our plans are just worth the time and effort on reflection . . . It is perfectly rational to follow a satisfactory plan when the prospective returns from further calculations and additional knowledge outweigh the trouble" (1971, p. 418). In short these writers are acknowledging both the desirability for and limitations of rationality in decision-making and are advocating that the discipline of rationality is worth aspiring to even though there are practical problems inherent therein. Allison (1971) has referred to this procedure as the 'organisational process' model or paradigm.

The Organisational Process Model

This paradigm asserts that policy outputs are largely determined by the organisation and its structure (Allison, 1969). It has elements

of rationality in that it assumes a known or established procedure for analysing issues, and that there are specific organisational routines available for remedying defined problems. Simon (1957) has called such behaviour 'bounded rationality' because of the limitations one has in understanding the totality of any problem, the environment in which the problem or issue is encapsulated, the demands on one's time are such that it is impossible to concentrate or focus solely on one issue, and further that the financial resources available are always restricted. For Simon, the operative mode is one of 'satisficing' - the first alternative that meets a pre-selected or pre-determined set of criteria is chosen. Thus a filter mechanism is in operation and one in which "decision-makers filter the environment through their prior orientation (and) features that do not fit in with their attitude tend to be rejected" (Allen, 1979, p. 114-5).

Simon's concept of 'bounded rationality' has been severely criticised because it has its roots in the rational model of decision-making and therefore "remains vulnerable to the same criticisms" (Rhodes, 1979 p.33). Ham and Hill (1984) fault Simon's model on four grounds: firstly, as organisations are not homogeneous there will be conflict over which values and objectives are to be pursued; secondly, they argue that it is nonsense to suggest that an organisation can have goals; thirdly, decision-making rarely, if at all, follows a logical path; and fourthly, the decision-making process does not identify a mechanism for separating facts and values, and means and ends. What these critics are criticising is the prescriptive nature of Simon's model, however such strictures can be likened to the debate over what came first, the chicken or the egg; what is important is not so much

what evolved first but rather that there is a model with which to relate. Nonetheless, Simon's model is flawed because it assumes that corporate identity overrides the views of groups or individuals within the organisation. This view may appear to be acceptable for a profit motivated organisation but when the organisation is a public body, such as the National Health Service, with an array of competing groups each with their own perception of, not only, what the problems are, but how they should be solved, then Simon's paradigm breaks down because such an organisation cannot speak with one voice.

The theory of organisation decision-making as developed by Cyert and March (1963) is a model which attempts to overcome some of the difficulties previously identified, although it has its roots in Simon's paradigm. They start from the premiss that the organisation is a coalition of individuals and/or groups each of whom have particular goals in mind for the organisation. The crux of Cyert and March's model of the behavioural theory of organisation is based on four related concepts which are applied sequentially:

"- quasi-resolution of conflict;
- uncertainty avoidance;
- problemistic search; and,
- organisational learning." (Allen, 1979, p.118)

In short the model firstly assumes that the goals of the members of coalitions are always in conflict and that this conflict can be reduced by arguing that the goals themselves are constraints on the decision-making process. Thus goals are seen as nothing more than" a series of independent aspiration-level constraints imposed on the

organisation by members of the organisation coalition" (Cyert and March, 1963, p.117). Furthermore goals are attended to one at a time which means that any conflict between goals can conveniently be ignored.

Secondly, organisations avoid uncertainty by focussing on the short-term aspects of the problem. They eschew decisions which have long term implications particularly when the outcome cannot be reasonably accurately forecast or where it is beyond their capability to influence or control. Thirdly, problematic search, implies that problems can be easily identified, usually as a result of the organisation having failed to satisfy a particular goal or set of goals and that there is a reasonably simplistic or straightforward mechanism for dealing with the problem once known. Simon's (1957) concept of problem 'satisficing' is very apt here as the procedure suggested by Cyert and March differs little from that outlined by Simon, in that a problem is solved either by ensuring that it conforms or equates to known criteria or by reconsidering the goal itself.

The fourth and final factor of Cyert and March's model is that organisations learn in the sense that they exhibit adaptive behaviour as a result of working through the model. Goals become changed according to previous established and agreed goals, performance criteria become more refined or amended, and the rules by which the organisation responds to problems also become modified. And thus the procedure is repeated for each specific problem. The difficulty with this approach to decision-making is that it appears to ignore the political dimension. It assumes that internal or sub-group conflict

can be minimised by ignoring it, and it also assumes that all the groups or elements within the organisation, whatever their internal difference, agree and share the same overall goal for the organisation. In other words, they may question how the organisation produces its goods but not the goods it produces. In public sector organisations the political environment within which decision-making occurs is very important because there is not necessarily an universal view of what the organisation should be doing. In this case, understanding the political dimension is paramount if one wishes to understand decision-making in the public sector (Pettigrew, 1973).

A final criticism of the organisational process model of decision-making is that its focus on the organisation is at the macro or executive level and consequently does not attempt to discern how those at the lower order levels participate in or influence the decision-making process (Burns, 1969; Rhodes, 1979). Thus the model naively assumes that lower order groups have little or no power and also makes no attempt to appreciate the way in which the power that they may possess is distributed amongst these groups, nor the manner in which they choose to exercise their power.

The Bureaucratic Political Model

According to Allison (1967) this model of decision-making, which he labelled the 'bureaucratic politics paradigm', assumes that each player or actor in the decision-making process participates as of right, and that the decision outcome is a result of negotiation or bargaining. The implications of this is that 'power is shared' amongst the decision-makers. This does not necessarily imply

equality of power for as Allison acknowledges "positions define what players may and must do" (1969, p.709). He also recognises that the players or actors in the decision-making 'game' come to it with pre-determined values and perceptions of what is required of them and therefore that an individual's personality can be as (and possibly more) important and influential as the power he/she possesses.

Perhaps the strongest and most outspoken advocate of the political or incremental model as he prefers to call it, is Lindblom (1959; 1963; 1964; 1968; 1979) who, in effect, argues that there is no such thing as 'rational man', because the decision-making process is so complex that any attempt at instilling a rational order to the process is automatically rendered meaningless. In its place, Lindblom suggests using a method of 'successive limited comparison', a process whereby decisions are made on a continuing basis, taking one step at a time and then only by small degrees.

Lindblom has characterised the differences between the rational comprehensive model and his own method as follows:

"	Rational Comprehensive		Successive Limited Comparisons
1a	Clarification of values or objectives distinct from and usually prerequisite to empirical analysis of alternative policies	1b	Selection of value goals and empirical analysis of the needed action are not distinct from one another but are closely intertwined.
2a	Policy-formulation is therefore approached through means and analysis: First the ends are isolated, then the means to achieve them are sought.	2b	Since means and ends are not distinct, means and analysis is often inappropriate or limited.
3a	The test of a "good" policy is that it can be shown to be the most appropriate means to desired ends	3b	The test of a "good" policy is typically that various analysts find themselves directly agreeing on a policy (without their agreeing that it is the most appropriate means to an agreed objective).
4a	Analysis is comprehensive, every important relevant factor is taken into account	4b	Analysis is drastically limited: i)important possible outcomes are neglected. ii)important alternative potential policies are neglected. iii)important affected values are neglected.
		5b	A succession of comparisons greatly reduces or eliminates reliance on theory." (1959, p. 80)
5a	Theory is often heavily relied upon.		

For Lindblom "the science of muddling through" is a perfeclty legitimate method for determining policy or making decisions because "policy is not made once and for all; it is made and re-made endlessly" (1959, p.86). He justifies his procedure on three main grounds: firstly, that since the policy-maker does not nor could not ever hope to possess perfect knowledge of the situation, he/she compromises as best he/she can by not attempting quantum leaps in goal terms. In other words, because he/she is unable to predict outcomes beyond his/her or anyone else's knowledge, the policy-maker only makes limited or short inroads into a problem recognising that policy decisions are usually never final solutions to a problem. This procedure has been termed "disjointed incrementalism" because decision-makers move forward one step at a time with the consequence that policies only change marginally (Rhodes, 1979).

Secondly, because decision-making progresses cautiously a policy-maker is able to learn from past sequences of policy steps such that he/she will gain a reasonable understanding of the probable outcomes of further similar steps. This knowledge of what to do next is also partly derived from the degree of influence likely to be exercised by others in the decision-making process. Thus each decision-maker or 'partisan' is constantly and continually reconsidering or adjusting his/her decisions towards the interests and decisions of others. This process of 'partisan mutual adjustment' may not mean that there is complete agreement on the goals or objectives of a policy but that there is agreement, at least, on the course of action to be taken. In other words, decision-makers reach agreement on the decision to be

taken through a process of negotiation and bargaining (Barnard, et al, 1980a; 1980b).

Thirdly, and finally, as each decision advances sequentially this enables the decision-maker to test the relevance of his/her previous predictions. Essentially, this form of decision-making is remedial: that is, the decision was made to alleviate a known problem. If the issue has not been resolved by the decision, then a new method or approach is tried. Although this form of decision-making is essentially trial and error it does allow for past mistakes to be remedied fairly quickly because of the short time horizon of the process. Consequently policy decisions are essentially short term and are only taken within known information boundaries or constraints.

As with the previous models of decision-making, the incremental or political approach does have some drawbacks even though many commentators acknowledge that disjointed incrementalism "is a good description of how decisions are actually made in organisations" (Ham and Hill, 1984, p.83). Nevertheless despite its apparent relevance to the way in which organisations operate, there are a number of blemishes to the incremental or political model which are worth briefly highlighting. One of the major criticisms levelled at the incremental model is that it acts "as an ideological reinforcement of the pro-inertia and anti-innovation forces" (Dror, 1964, p.153). It is not seen as a force of and for change because it does not seek to alter the overall direction of the organisation. Another criticism is that the model is highly subjective; as Rhodes says "one man's increment is another man's revolution" (1979, p. 34). And finally it

appears that the model does not recognise or fails to appreciate that there are clear differences between competing groups and that they do not or are unable to compete on equal grounds thus reinforcing the view that the present is "the best of all possible worlds" (Rhodes, 1979, p.34).

There would appear to be little to distinguish between disjointed incrementalism and that of the principle of bounded rationality outlined by Simon (1957) where the decision-maker decides on the basis of the option or alternative which by some criteria is considered good enough. Likewise there are similarities between the rational, comprehensive and the organisational models of decision-making such that the latter appears in some ways to be a modified version of the former. Thus there is no one model of decision-making, rather there are elements of each to be found in the decision-making process. Or as Allison puts it these conceptual models are no more than a framework which "consists of a cluster of assumptions and categories that influence what the analyst finds puzzling, how he formulates his question, where he looks for evidence, and what he produces as an answer" (1971, p.245). Consequently, "if policy analysis is distinctive, its distinctiveness does not lie in a common theoretical stance" (Rhodes, 1979, p. 35). What then (if any) is the common thread?

Policy Analysis: A Framework for Decision-Making

Decision-making is an inexact science; indeed, there may well be some who would argue that it is not a science at all, but rather a fact of life. However one thing is agreed: namely, that decisions are

constantly being made by among others individuals, groups and organisations. It is this activity which policy analysis seeks firstly to understand and secondly to develop a structure or framework which would facilitate the phenomenon (Friend, et al, 1974). Essentially, policy analysis embodies two main foci: policy content - how and why policies are developed, and policy process - the procedure or methodology by which policies are made (Jenkin, 1978). Policy analysis is seen by its advocates as "an alternative or supplement to the more traditional methods of decision-making based on incrementalism, intuitive judgement and trial and error methods of operation" (Burt, 1974, p.1) because it seeks to bring some semblance of order or co-ordination to what has been hitherto an unco-ordinated process (Lasswell, 1951; Dror, 1971; Burt, 1974).

There is a problem here in that there is not an universally shared view that policy analysis is necessarily scientific in nature and scope. Some commentators suggest that its major contribution is as a conceptual framework for understanding the political environment of decision-making. Jenkin for example, sees policy analysis as being "concerned with the causes, nature and consequences of political action occurring at a variety of levels of government" (1978, p. 14). This view is also shared by Dye who defines policy analysis as "the description and explanation of the causes and consequences of government action" (1976, p. 1). Friend, et al, however, see policy analysis, not as a single or one-track entity but one which attempts "to preserve a balance between representing the structure of complex decision problems and ... representing equally complex patterns of human and organisational relations" (1974, p. 23). But perhaps the

most wide-ranging description of policy analysis belongs to Wildavsky (1979) who defines it as incorporating such attributes as: descriptive - problem identification; prescriptive - advisory; selective - key actor oriented; objective - outlines alternatives; argumentative - rational behaviour; retrospective - draws on the past; inventive- fosters innovation; prospective - forward looking; and subjective -value conditioned. Clearly Wildavsky's definition of policy analysis leaves nothing to chance. What it does highlight is that there is no definitive definition of or for policy analysis. Its real purpose according to Wildavsky is to identify "problems that decision-makers are able to handle with the variables under their control and in the time available" (1979, p. 15-16).

This leads on to the question of how this can be done and to provide an answer it is necessary to consider the various characteristics of policy analysis. According to Rhodes (1979) policy analysis has four features: analytical; multi-disciplinary; problem oriented; and client centred. Burt (1974) claims that the strength or distinguishing characteristic of policy analysis is its reliance on the scientific method which implies that decisions can be tackled in a prescriptive and systematic manner. He suggests a five stage procedure: formulation - problem determination; search - information gathering; explanation - model building; interpretation - option selection; and, verification - evaluation of outcome.

Jenkin (1978) whilst accepting that policy analysis is largely systematic raises the fundamental question of whether it is analysis of policy or analysis for policy with which one is concerned. In

Jenkin's view these are two quite distinct issues. The former, is concerned with a better understanding of the procedure of policy analysis, whereas the latter focuses on the applied nature and in particular on its contribution towards helping to resolve social problems (Ham and Hill 1974). Jenkin however argues that policy analysis while grounded in a systems perspective must also have an organisational behaviour focus because "both the substance and the process of policy are centrally dependent on the inner dynamics of political and administrative organisations, and that this is of importance whether one wishes to understand or amend the system" (1979, p. 82).

To some extent, Friend et al (1974) agree with Jenkin's view but they argue that his perspective is wrong: too much attention directed towards the top of the decision-making tree - 'the decision-takers' and not enough towards those within the organisation who help to mould opinion - 'the decision-makers'. The distinction, according to Friend, et al, is crucial because it is misleading to assume "that the actors within a policy system must all owe allegiance to a single corporate organisation" (1974, p. 27).

Friend and his co-authors consider the policy analysis framework (or as they call it, the policy system) as a vehicle for decision-making but one which is descriptive rather than prescriptive. They argue that the policy system must be flexible, that is adaptable to the 'class' of decision problems facing policy-makers. They recognise, however that even a system with maximum flexibility must contain some common elements. These common or key components are described as:

1) actors - the people involved in the decision process for the particular problem at hand;
2) action space - the environment within which the decision-making process occurs;
3) internal relations - the way in which the key actors in the decision-making process relate to one another;
4) external relations - outside factors which may influence the decision and which may be beyond the control of the actors; and
5) policy guidelines - the set of rules acknowledged by the actors as being applicable to the decision problem.

The collective view seems to regard policy analysis as a multi-faceted activity, and one which the literature suggests encompasses a variety of apparently conflicting tasks. These seem to range, on the one hand, from the so-called 'ideal' or technical approach whereby policy choice is facilitated through the objective analysis of data, options or alternatives assessed according to known and/or agreed criteria, with the most appropriate choice or course of action emerging. On the other hand there are those who argue that the policy-making process is essentially one of negotiation and bargaining in which goals are not explicitly articulated and the various actors involved are not necessarily willing to specify their overall objectives because neither are they sure about the overall aim of the policy nor do they wish to unduly restrict or limit their manoeuvrability or bargaining power (Higgins, 1980; Lee and Mills, 1982).

About all that can be said for policy analysis, with any certainty is that there is no one activity called policy analysis, rather it incorporates a range of approaches and tasks, and the mix employed is largely dependent upon the problem at hand (Friend et al, 1974; Ham, 1980a). Given that the policy process is so complex and open to a variety of different interpretations it is perhaps not surprising that it is in the health sector that decision-makers saw planning as a potentially useful vehicle for not only assisting or aiding policy development but also for implementing such policy.

Planning and Policy-Making in Health Care

The common thread, hitherto lacking in the discussion, comes from the desire to ensure that the policy (decision) making process has a sense of structure or order about it, such that the policies determined will be universally accepted and implemented. Planning or policy analysis provides such a framework because "it includes not only thinking up ideas but also facilitating their application" (Wildavsky, 1979, p.10). Thus to Wildavsky policy analysis (or planning) is both an 'art' and a 'craft'. The 'art' lies in "thinking up ideas"; that is the use of creativity and imagination in problem solving. The 'craft' lies in the skills which are necessary to ensure that such ideas become a reality.

Self (1981) argues that there is a case for an increase in emphasis on policy-making and planning because of the multiple 'overloads' facing organisations. These overloads he contends are:

i) 'allocational overload' - in the case of the health sector this can be described as the problems of reconciling limited or finite resources with unlimited or infinite demand on these resources.

ii) 'System overload' - the desire for greater control or regulation over the way in which the organisation functions and how it relates to its external environment.

iii) 'political overload' - in health care the problems of reconciling different perspectives of care, such as, in Britain the current debate about the public/private mix in health care.

iv) 'international overload' - vulnerability to shortages of resources and the distortion caused by the shift of scarce resources between the different health care systems in different countries. The problems caused, for example, by the mobility of the medical profession affect not only the donor country but also the recipient country.

Self is realistic enough to acknowledge that planning of itself is not a panacea for the problems outlined above but he does assert that "the case for more effective methods of planning is powerful" (1981, p. 222), not because of a desire for greater rationality in decision-making but rather in recognition of the societal pressure on organisations to tackle the problems confronting them.

How should organisations go about such a task? In trying to answer this question one is immediately confronted with a problem and that is that planning can be conceived of in at least two different ways: firstly, "as a 'backroom' activity concerned with the formulation of policies (policy planning)" and secondly "as a framework for the co-ordination of particular policies and decisions" (Self, 1981, P.222).

Whereas Self has suggested a two dimensional role to planning, Blum (1981) has identified no less than eight categories or modes of planning (figure 3.2). What this clearly demonstrates is that planning as an activity is just as difficult to compartmentalise as are decision- making theories.

A Rationale for Health Planning

However the question remains, what is planning? It is generally regarded as a means by which policies are converted into action. Thus the planning process can be seen as incorporating policy analysis as they share some common elements as well as similar theoretical backgrounds (Faludi, 1975; Paris,1982; Healey, et al, 1982). As with policy analysis, defining planning as an activity creates problems as no two definitions are alike, although there does appear to be a sharing of some common concepts. For example, Kahn describes planning as "policy choice and programming in the light of facts, projections, and application of values" (1969a, p. 16), whereas in Dror's opinion "planning is a process of preparing a set of decisions for action in the future, directed at achieving goals by preferable means" (1973, p. 330). Blum (1974) however, has taken a much more eclectic view when he suggests the following definitions of planning:

- as an aid or replacement for political decision-making;
- as a means of anticipating or looking ahead;
- as a means of improving or fostering social justice;
- as a means of improving the logical or scientific calibre of problem solving;
- as a methodology and a machinery for turning ideas into blueprints for action;

Figure 3.2

MODES OF PLANNING

LAISSEZ-FAIRE	Intervention is not necessary as market forces will ultimately resolve the issue.
DISJOINTED INCREMENTALISM	Intervention only in order to ameliorate present problems by responding to political crisis.
ALLOCATIVE	Resources allocated to remedy current problems or to avoid potential problems. Satisficing.
ARTICULATED OR GUIDED INCREMENTALISM	Intervention focuses on both present and immediate future problems. Attempts to reduce uncertainty in problem solving.
EXPLORATIVE	Explores options available for any given issue selects most appropriate one and makes necessary changes to achieve goal. Has a forward looking approach. 'Planning towards the future'.
NORMATIVE (Goal Seeking)	Decides what sort of future is required and then sets about making the modifications necessary to realise that desired state. 'Planning from the Future'.
TOTAL PLANNING	An amalgam of most of the foregoing models in that it encompasses planning not only day to day activities but also for future requirements.

- as a sort of 'arbitration' service for obtaining good, democratic and equitable decisions; and
- as a means of control.

What most, if not all, of these definitions share is the belief that planning is a logical and formative process based on the concept of change and embodying the view that such change is manifestly of value and therefore desirable. From this it is possible to fashion a 'standard definition of planning' which in the view of Lee and Mills goes something like this;" the process of deciding how the future should be different from the present, what changes are necessary, and how these changes should be brought about" (1982, p. 30).

At this juncture it is worth recalling Crossman's (1972a) definition of planning as "making choices about life and death". This sobering view is a good reminder that planning is not only a technical process, it is also a political and social process. The clear implication of Crossmans's statement is that over-emphasis on one side of the equation could have unfortunate consequences for some segments of society because planning problems are not matters to be considered in the abstract since their eventual outcome impacts upon people's lives.

This theme has been pursued, albeit in ideological terms, by Parston (1980) and Tannen (1980) who both argue that current approaches to health planning have concentrated on the regulatory and medical manifestations of health care, to the neglect of the health needs of society in general. The crux of their argument is that health

planning as it is called has not taken place, instead the focus or emphasis has been on medical services planning. This they contend is almost entirely due to the undue influence exerted by the medical profession on the policy-making process in particular and on planning in general: an issue which will be addressed more fully in chapter seven. The purpose of briefly highlighting the matter here is to reinforce and underline the point made earlier that planning as well as policy analysis and decision-making is very much a product of the environment in which it occurs. However, in spite of the differences in opinion as to what should be the focus of planning, there is at least consensus in the literature that planning as a concept and an activity is both desirable and necessary.

Towards a Social Theory of Health Planning

Unless one understands the context within which all forms of planning, especially health planning, operate it is most unlikely that the products of the process will be judged as being what society wants and/or needs. This implies, of course, that such terms as 'health' and 'society' can be satisfactorily defined so that their meaning is clear and acceptable to all. Therein lies the planner's and policy-maker's dilemma - there is no universally accepted definition for these terms and where a definition is imparted the result is often so vague as to be virtually meaningless in the sense that is raises more questions than it answers. The World Health Organization's (WHO) definition of health as being a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity, is a case in point. The attainment of the WHO definition of health may not be all that desirable since it may raise

expectations of health and demand for health care to such an extent that they cannot be met; indeed, they may be impossible to acheive. Definitional difficulties such as these led planners to search for paradigms which, while recognising the desirability of definitional consensus, would facilitate the development of planning "as a general societal management process" (Healey, et al, 1982, p.5): Healey, et al, go on to argue that this 'procedural' planning was by the late 1970s much discredited largely because of the discord between theory and practice (Alexander, 1984) with "many planning practitioners doubting the relevance of much existing planning theory" (Healey, et al, 1982, p.6). Before pursuing further this 'paradigm breakdown' within the context of health (social) planning, a short journey into the origins of planning seems warranted in order to provide a backcloth to the ensuing discussion.

Planning Geneology

Planning as it relates to the built environment is very old as the ancient cities of Egypt, Greece and Rome attest; however, as an established profession it is comparatively young, dating from this century (Midgley, 1984). The earliest forms of formal planning were those developed to bring order and design to urban society and this form of planning had its antecedents in the growth of the urban environment. The Industrial Revolution provided the watershed for urban planning which arose in response to the many social and economic problems caused by the rapid acceleration in industrial development. The economic impact of the Industrial Revolution saw scores of people, mainly from the countryside, come flooding into cities and towns. Villages grew almost overnight into large towns and cities. The

problem was not one of economic opportunities in these towns and villages but the lack of the necessary social facilities such as housing, public services, health and education to cope with this sudden influx of people. People thus had to endure appalling conditions both at work and at home.

The poor home environment led a number of industrialists to the conclusion that a healthy workforce was a better workforce. This philosophy was endorsed by a number of industrialists in the late 1800s such as Salt (Saltaire), Cadbury (Bourneville), and Lever (Port Sunlight) in the United Kingdom (UK) and Pullman in the United States (US), who built towns around their works and endeavoured to combine working and living in a healthy environment. This idea of harmony between working and living was enthusiastically endorsed by the so-called pioneers of modern planning - Louis Mumford, Ebenezer Howard and Le Corbusier, and led directly to such ideas as 'Garden Cities of Tomorrow', the social city, the segregation of different land uses, and the development of high density, open space housing (Hall, 1974). In essence, however, these early planners were concerned with physical solutions to complex issues and there was the naive belief that a new urban form would resolve many of the socio-economic problems inherent in an urban environment.

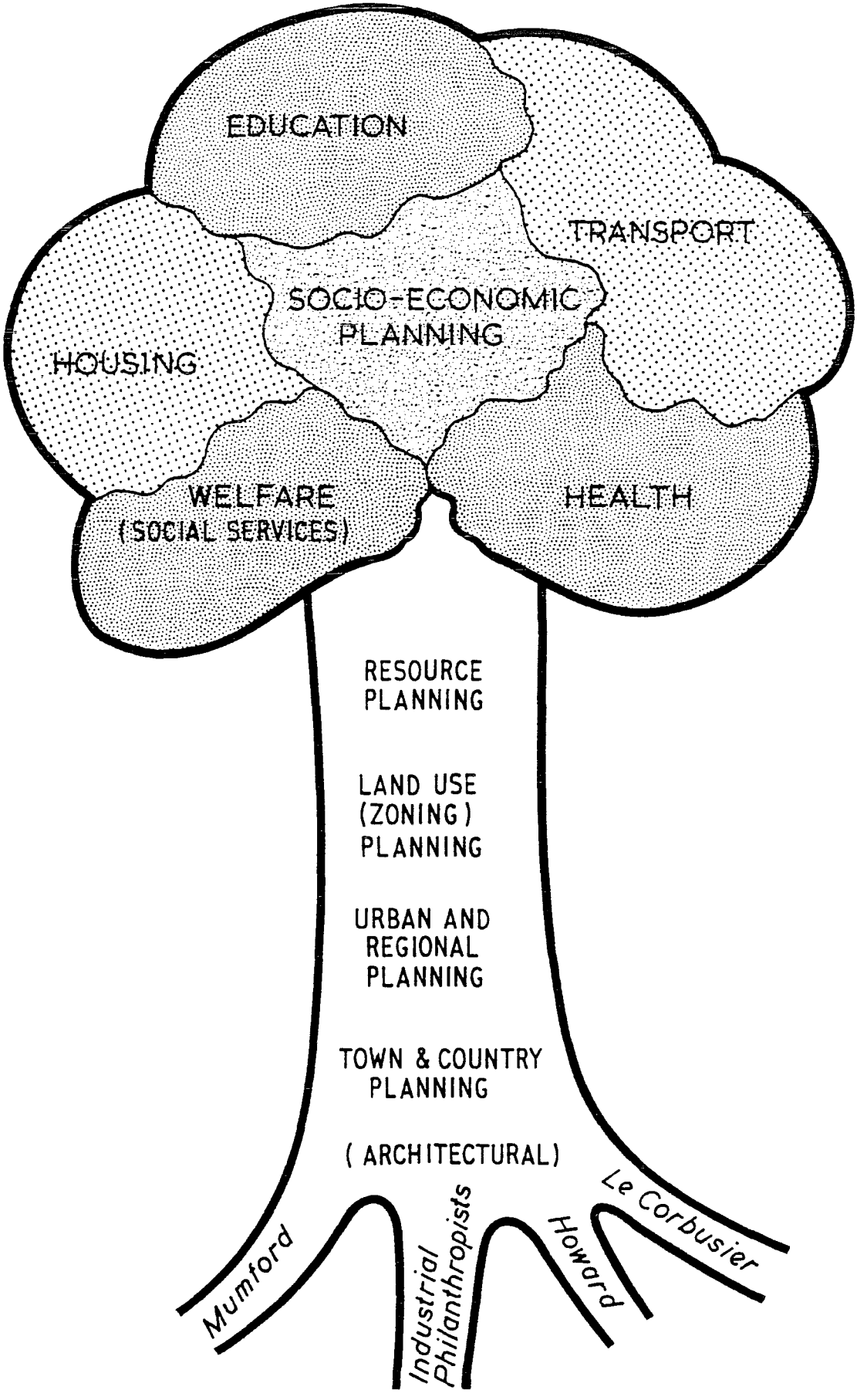
It was during this period (late 1800s, early 1900s) that social welfare planning also originated. In the US, social welfare planning or social planning grew out of the model city concept and the Charity Society Movement (Gilbert and Specht, 1977). Social planning in the UK also had similar roots, although the process started earlier with

the Public Health Act of 1848, the Sanitary Act of 1866, and the Public Health Act of 1875. These Acts established sanitary controls and invested power in local authorities to enforce these controls (Hall, 1974). However, it would be fair to say that this so-called 'social' planning was largely concerned with the physical manifestations of change and not necessarily, other than indirectly, with fundamental societal changes. For example, good health was seen as a function of adequate sewage, pure water and so on, not as a function of a basic health care structure.

Planning as an activity, came into its own following the Second World War. In the aftermath of the War the desire to build a 'better' society upon the foundations of the old, was very strong on both sides of the Atlantic. In the US the emphasis was mainly on Planned Economic Development whereas in the UK the extensive war damage meant that greater attention was given to land use development and associated activities (Hall, 1974).

From this base planning has developed so that it embraces not only land use or as it is often referred to, town and country planning, but also aspects of social planning, from housing and education, to health. A conceptual view of how the various branches of planning have evolved is shown in figure 3.3. However, in so doing, the basic underpinning philosphy of planning has changed from a concern with the physical environment as the key to a better society, to a debate about the inter-relationship of the very factors with which society is composed (Conyers, 1982). It is within the framework of the wider

Figure 3.3. A CONCEPTUAL VIEW OF THE EVOLUTION OF PLANNING



debate that the social concepts and processes of health planning are to be discussed.

Social planning of which health planning is one aspect, shares many of the characteristics discussed above, and indeed, is open to the same criticisms. Advocates of social planning argue that it can be distinguised from other types of planning on the grounds that it is concerned with social reality (Kahn, 1969a; 1969b; Mayer, 1972; Eversley, 1973), and as such "deals directly with social issues and problems" (Midgley, 1984, p. 15). Social planning, although grounded in rational decision-making, eschewed the 'architectural determinism' favoured by urban or town planning and instead focused its attention on the human element (Broady, 1968; Gans, 1968). Thus for social planners the determinant and dominant factor was people and therefore social planning was concerned with promoting and fostering social relationships between people (Broady, 1968).

In health care terms, this relationship has been described as the 'health field concept' (Lalonde, 1974) or the 'diamond-model' (Long, 1984). The 'health field concept' sees health care as comprising four main components: human biology - man's inherent susceptibility or resistance to disease and illness; environment - the conditions (social, economic, cultural) in which one lives; life style - the manner in which one chooses to live and the regard one holds for personal health; and, health care organisation - the structure created for the provision of health care facilities and services. The rationale underpinning the 'health field concept' is that these four elements are <u>not</u> mutually exclusive, each impinges upon the

other, so that the changes in one will impact to a varying degree on the others. Long's Diamond model adds a fifth element to those comprising the health field concept; the interface between health and illness. It is arguable whether this is a truly separate component or just an academic refinement of the original four. The fact that there are four or five elements is largely incidental since both models admirably demonstrate that health care cannot be divorced from the wider milieu in which it is placed.

If one accepts that substance of this supposition, it logically follows that the planning of health services must also be faithful to the philosopy of the health field. Therein lies the difficulty. It is clear from the volume of literature on urban planning (Harvey, 1973; Goldsmith, 1980; Healey, et al, 1982) and to a lesser extent that on social and health planning (Midgeley and Piachaud, 1984; Parston, 1980; Gilbert and Specht, 1977) that the developments in planning have not kept pace with societal changes (Healey, et al., 1982; Paris, 1982). This is true in the field of health (Parston, 1980) and Dear (1984) attributes this to the extensive and ill-defined field of health services planning; a consequence of the fact that the field is highly fragmented. Even so, it appears that three broad categories of study can be distinguished; disease ecology; accessibility to and utilisation of health care; and, organisation structures of health services (Dear, 1984).

Dear further argues that these three branches of health services planning, while important because they determine the nature of the health care facilties provided, are regarded as separate and distinct

entities so much so that an overconcentration on those well-defined problem areas is preventing a necessary analysis of the wider context of illness, health, and society . The solution, advocated by Dear, is for a social theory of health embodying three main elements: conceptual - a concern for the way in which health care as an institution has evolved; practicable - the structure and application of health care resources; and contextual - health care must be firmly set within the broader political spectrum.

Dear's newfound advocacy for a social theory of health may be a relatively new concept for a geographer (which he is) however this has been apertinent issue in health planning for some time now. Indeed, some of the recent literature on health planning has focused on this theme (Parston, 1980; Haywood and Alaszewski, 1980; Lee and Mills, 1982). Proponents of a social theory of health planning acknowledge that it is the interaction between the various actors in the process (providers, planners, patients) and the community at large which is of crucial importance. What seems to be less clear is how these various actors interact; it is this process which requires illumination and is a subject which is returned to in Chapter Seven.

So much for theory but what actually happens in practice? Do decision-makers behave in a rational manner as most proponents of policy analysis and planning advocate or do they largely react to events beyond their ability to control? In a sense the answer is contradictory because the literature suggests that decison-makers not only respond in a proactive (rational) way but also in a reactive (incremental) manner. Thus it could be argued that decision-making,

policy analysis or planning is ruled by paradoxes - a point emphatically made by Wildavsky (1979).

Inspite of these conceptual difficulties most commentators argue that planning is a vauable tool or aid to decision-making. Most agree that if planning is to be meaningful then it must proceed in a sequential or cyclical fashion which begins with problem definition as the first step on through until a policy and/or a programme is implemented. However, the activity does not cease with implementation because the process itself creates changes which in turn produces different problems and/or variations of the original problem, such that the whole procedure is repeated.

The trouble is that things in life, of which decision-making is one, are not so simple. They are inordinately complex and this creates difficulties when it comes to devising a procedure or system for responding to life's problems.

Theoretical explanations of how things occur or develop are not always borne out in reality. Having said this, theories of decision-making, policy analysis and planning are both useful and valuable in that they aid understanding of complex processes. However it would be unwise to read too much into the desire for structure or orderliness in planning and policy-making partly because of the strong pressures on policy-makers not to threaten "the social order and established social relationships" (Crichton, 1981, p. 29), and partly because the decision-making process is essentially one of 'trade-offs' and 'bargains'.

Policy-making and the plans associated with them is an imprecise process; as Crichton has observed, "some policies may have evolved within organisations and become structured into the fabric without really being recognised as policies by many, and that other policies may be very consciously worked out and presented to constituents for consideration, adoption and implementation" (1981, p.30). Crichton argues that those policies which have evolved within the organisation have been largely ignored by students of policy-making because they do not appear to conform to the established or traditional model of policy-making. Nonetheless, evolved policies may be just as important in introducing changes within organisations as the more accepted mode; that is where policy issues are discussed against a known and understood background according to a pre-determined procedure. It is this comparison which underpins much of the investigation and analysis described in the rest of this thesis.

The investigation and analysis is not solely confined to a study of the impact of variations in the policy-making process, it also considers what Rodwin has identified as 'the health planning predicament'; namely the questions of "who should participate in health planning and whose interests health planners should serve" (1981, p. 231). These questions are of fundamental importance for both planners and policy-makers who have what some might consider a thankless task in that somehow they must reconcile a seemingly unlimited demand for health care at a potentially unlimited cost within a strictly limited resource base. How they manage to do this (if at all) is the thrust of the research to be described herein, and

where a number of the assumptions underpinning the planning and policy-making process discussed above will be critically evaluated. However, before commencing such a task, it is first important and necessary to describe the development of health planning in the NHS.

CHAPTER FOUR

THE NHS PLANNING SYSTEM - A REVIEW

This chapter describes the background to the creation and introduction of a formal planning system in the National Health Service (NHS). It is both important and necessary to understand the rationale underpinning the NHS planning system in order to appreciate the manner in which planning has been practised in the Health Service. After setting the planning scene with regard to the NHS, the chapter goes on to reflect on a particular conceptual model for health planning in order to firstly suggest a theoretical framework within which planning should function, and secondly as a mechanism for testing out the way in which planning was actually practised in the NHS.

The creation of the NHS in Britain was grounded in the notion that 'health' was a national asset and that every citizen regardless of financial means, age, colour and creed had a 'right' to this asset. Implicit within this 'right to health' was the concept of equal opportunity and access to health care for the country as a whole. Such laudable objectives were unfortunately founded on a misconception; namely that once health care became a 'free good' the health of the people would improve to such an extent that expenditure on health services would decline because of falling demand.

Thé fallacy of such a view soon became evident with a seemingly exponential relationship between health care expenditure and demand. The more resources devoted to health, the greater became the demand for care and for more resources to meet that demand. This spiralling effect of demand for health care on expenditure quickly became a cause

for concern. This concern was manifested through the establishment of a committee of inquiry (the Guilleband Committee) specifically charged with the responsibility to investigate the costs of the NHS. The report of the committee recommended, among other things, that more not less resources should be committed to the NHS (MOH, 1956) with the consequence that "attempts to constrain spending were replaced by a policy of commitment to real growth for nearly twenty years" (Bevan and Spencer, 1984, p. 95).

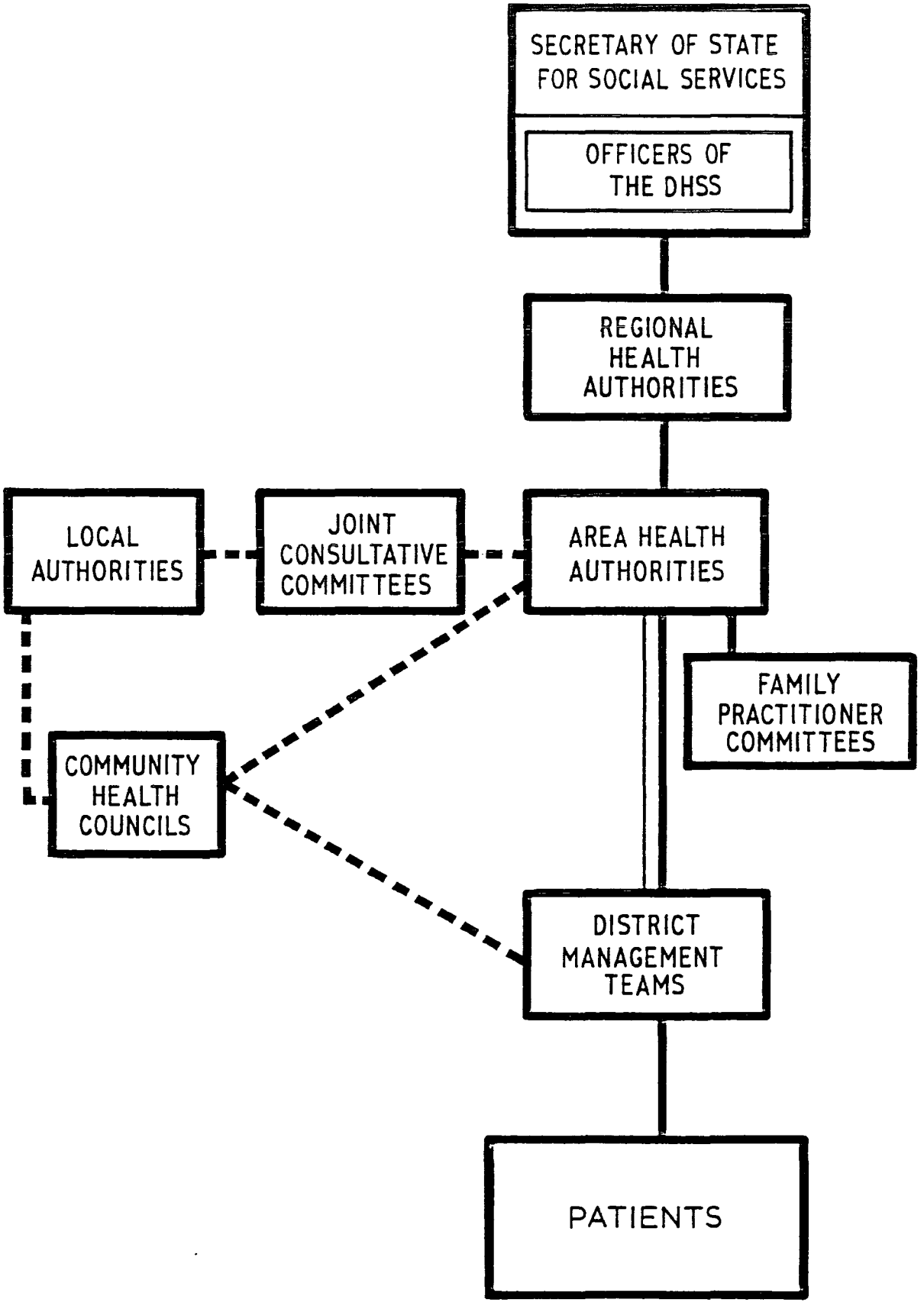
Despite this early attempt to question the efficiency and effectiveness of health services expenditure it was evident that overall concern for the manner in which these resources were being employed did not appear to be on the political agenda even though questions had been raised about the wisdom of such a philosophy (Carter and Peel, 1976; Cochrane, 1972). Central planners, if not primarily concerned about the effectiveness and efficiency of the NHS, did not attempt to influence the manner in which resources were allocated. The system operated in such a way that those areas of the country which had a reasonable or high level and standard of care got more resources whilst the poorer or less well-endowed areas received little. Thus the system had an inbuilt distributional bias against the poorer regions which was recognised and the 'Crossman' formula (1972b) was an attempt to rectify this anomaly. Under the formula resources were allocated to the various regions on the following basis: 50% according to the populations served; 25% according to the number of beds; and 25% according to the number of cases treated. It was evident that this method, whilst an improvement, still favoured to a large extent the wealthier regions. This is not altogether

surprising given the tripartite structure of the NHS in which responsibility for patient services was split between Regional Hospital Boards (hospital facilities); Local Authorities (health visiting, home-nursing) and Family Practitioner Committees (general medical, dental, pharmaceutical and optical services). Rumblings of discontent with this tripartite arrangement were frequently heard during the 1960s and early 1970s which culminated in proposals to radically alter the structure and organisation of the NHS (DHSS 1972). The essence of the case outlined in Management Arrangements for the Reorganised National Health Service was that the hospital based services of the Regional Hospitals' Board should be amalgamated with those health-related activities of the local authorities. Family Practitioner Committees were largely left intact but their mode of accountability was changed. The revised managerial arrangements which were implemented in 1974 are depicted in figure 4.1.

A Rationale for Planning

The rationale for such a fundamental change lay principally in a desire to integrate and improve the services for patients. Implicit in this 'patient-centred' approach was the notion that the decentralisation of decision-making could be counter-balanced by greater accountability. As the Departmental document put it, "delegation downward should be matched with accountability upwards" (DHSS 1972 p. 10). It is one thing, however, to advocate such a laudable goal, it is another to realise it when no procedure or mechanism previously existed within the NHS for translating goals into reality. Prior to the 1974 re-organistion of the NHS, no official mechanism existed for achieving 'delegation downwards, accountability

Figure 4.1. THE STRUCTURE OF THE 1979 HEALTH SERVICE ORGANIZATION IN ENGLAND



upwards' and as this slogan was clearly a "vital element in the management of the NHS" (Lee and Mills, 1982, p. 140), it became incumbent upon the government to find one. One such tool which seemed to have particular relevance to the health care field was PPBS (planning, programming, budgeting system).

PPBS was regarded as being particularly relevant for the health sector, because it was developed to encompass the two main concerns of how health service policies are developed and the manner in which they are implemented. Thus PPBS was seen as providing "an appropriate structuring of the planning debate, and to introduce an explicit link between planning and budgeting" (Lee and Mills, 1982, p.81). Unfortunately expectations were far greater than its achievements; indeed, its acceptance within the U.S. Department of Health, Education, and Welfare was not unequivocable, nor did it achieve the hoped for success (Rivlin 1977). The experiment with PPBS in the US Federal agencies also was not successful as had been hoped such that they rapidly became disillusioned with the systems approach and began to search for other approaches. Failure in the US, however, did not prevent other countries from considering PPBS for themselves.

The Department of Health and Social Security (DHSS) in Britain began to experiment with PPBS, or 'the programme budget' as they preferred to call it, during the late 1960s and early 1970s. The DHSS came to the view that programme budgets were inappropriate for operational management and should be used primarily for planning. The rationale for this was that health policies were more usually expressed as

services instead of outputs (Banks 1979). Three reasons were put forward for the DHSS using programme budgeting as a planning tool:

1. "to assist in the DHSS internal planning system;
2. to act as a basis for guidelines to the NHS;
   and
3. to act as a means for monitoring and control." (Lee and Mills, 1982 p.86).

Thus, increasingly in the 1970s the programme budget became the basis on which guidance was issued to the NHS on future strategies.

The documents Priorities for Health and Personal Social Services (DHSS, 1976b) and The Way Forward (DHSS 1977a) are examples of the programme budgets developed for specific services by the DHSS as "illustrative indications of the national long-term direction of strategic development" (DHSS 1977a, p. 15). Here, programme budgeting was considered to be an appropriate mechanism for costing policies; for evaluating priorities within realistic financial constraints; and as a forum for examining future strategies.

At the same time, as the DHSS became convinced of the merits of programme budgeting, it was becoming equally concerned about the state of planning in the NHS. Health services planning was extremely fragmented with the dominant mode of planning being hospital or capital planning, not service planning. It was called capital planning primarily because the finance for hospital construction came from capital monies - monies specifically earmarked for building construction, repairs, and/or maintenance. The focus on capital-led

planning stemmed from the publishing in the early 1960s of the Hospital Plan for England and Wales (MOH 1962) which articulated the concept of the District General Hospital, comprising a relatively standard set of medical and surgical specialities to service a pre-determined population base. Little consideration was given within the document to the health services in support of, or complementary to, those contained within the hospital setting.

This over emphasis on capital planning per se, was increasingly considered inappropriate for dealing with the increasing complexities of the NHS. Most chracteristically it reflected an 'incremental' approach to planning - a reactionary form of planning responding to specific events or crises as they arose - and was considered most unsatisfactory by central policy-makers. What was required it was claimed was a more rational and comprehensive form of planning.

Three inter-related factors can be advanced to explain the progression towards, and eventual adoption of, a rational comprehensive planning model for the NHS. Firstly, there was a growing awareness of, and interest in, the ideas associated with corporate management. Secondly, there was increased pressure exerted on all central departments by both the Treasury and the Public Expenditure Survey Committee (PESC) to contain costs and to present their financial forecasts in a more comprehensive and rigorous manner. The third factor for a 'different' planning approach arose because of developments occurring in the NHS. The continued improvement and expansion of high technology medicine and the costs associated with it, led the Service to give some considerations to the evaluation of

the care being provided and to ways of providing such care more effectively and efficiently.

Thus a rationale for introducing a formal planning system for the NHS was established: the concern to move away from the fragmented and capital-led planning of the 1960s and early 1970s; the desire to integrate and improve the services for patients; and the wish to make the planning of these services more responsive to the 'needs' of the patient. This was stated in the following terms: "health services can only be evaluated in relation to the identifiable needs of the community for different kinds of health care (which) must be expressed in terms of proposed developments of the components parts" (DHSS, 1972, p 50-51). In other words, planning was considered important as a means through which change could occur whilst ensuring that the proposed changes were compatible with the perceived needs of the community.

The mechanism for translating this philosophy of planning into reality was described in the manual The NHS Planning System (DHSS 1976a). The foundation of the NHS planning system was its emphasis upon the 'rational comprehensive' model of planning. It was 'rational' in that it assumed that all planning issues could be objectively appraised and a decision taken solely on the merits of each proposal. It was 'comprehensive' in that it implied that all aspects of any particular issue or topic could be assessed, and the implications of any course of action weighed accordingly, thus ensuring that the 'best' or most appropriate choice emerged.

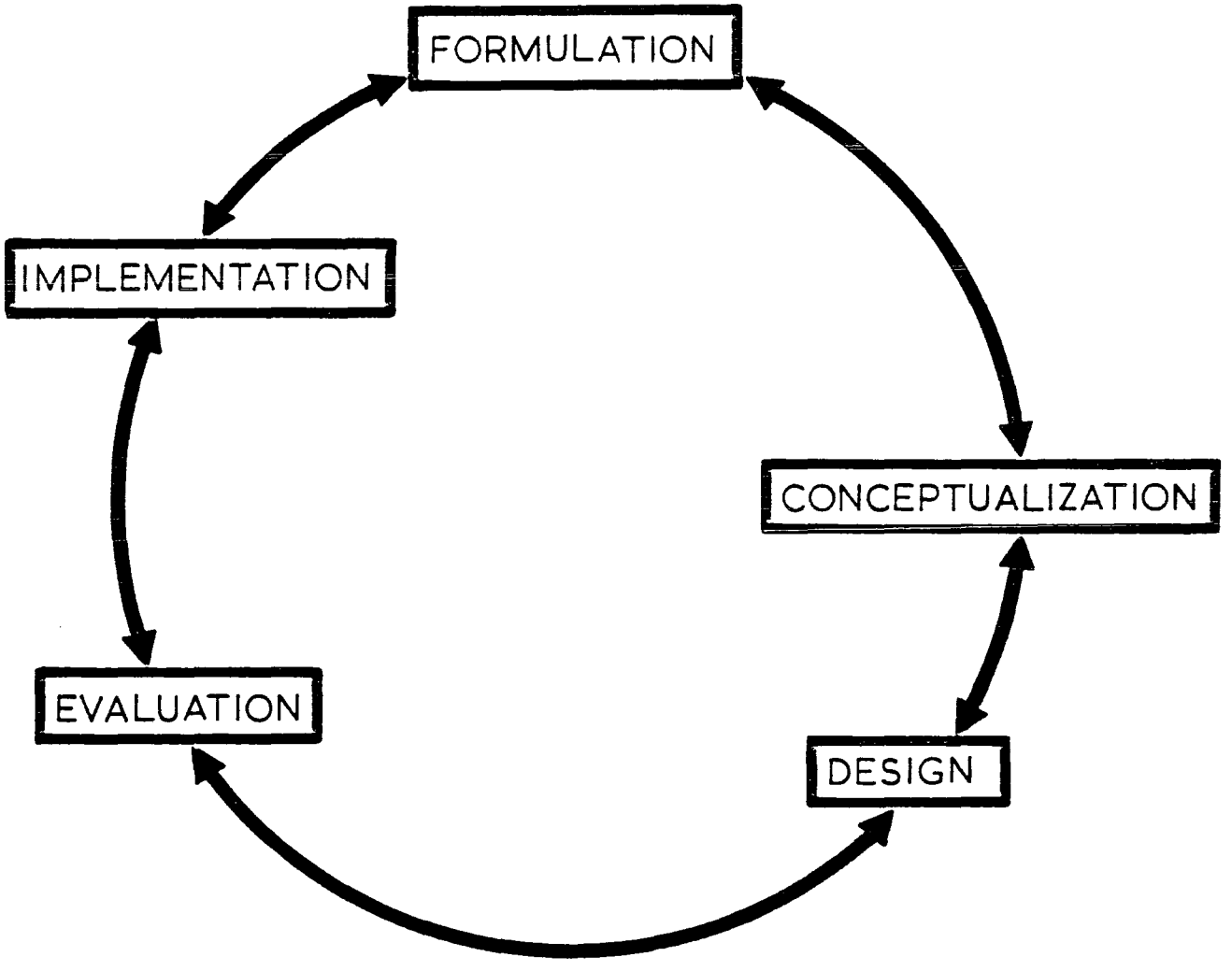
A Conceptual Model for Health Planning

There is also general agreement that if planning is about change then some sort of structure or methodology is needed to achieve this. There are almost as many planning methodologies as there are planning definitions and the analytical frameworks usually discussed bear a remarkable similarity to those of policy analysis considered earlier in Chapter Three. A critique of planning methodologies or frameworks will not be considered here since the same arguments in the foregoing chapter on policy analysis apply with equal force. Instead, the discussion will focus on one particular model or framework as an example of a planning system. The model outlined is very similar if not identical to the one introduced into the NHS.

Before considering each step or stage in the conceptual model it is first necessary to highlight a number of caveats. Firstly, the identification of a sequence of steps or a set procedure does not imply an attempt at introducing scientific rigour into the process, even though many would welcome such a step. Secondly, it must be acknowledged that what constitutes a planning or policy problem will differ greatly between the personnel involved. Thirdly, these differences will lead to the application of possible conflicting values and judgements on the part of those involved. Fourthly and finally, the procedure itself does not imply the existence of a panacea for health problem solving (Barnard, 1974).

Bearing these pitfalls in mind, it is now possible to describe the conceptual model of health planning (figure 4.2). The model documents five stages or co-ordinated steps: formulation;

Figure 4.2. A CONCEPTUAL MODEL OF HEALTH PLANNING



Source : After BURT (1974) and JENKINS (1978)

conceptualisation; design; evaluation; and implementation. The first step, formulation is the initialising stage, whereby the issues are defined, the objectives clarified, and the operational limits of the problem determined. It is here that decisions are made on what are the relevant factors or variables which contribute to the problem and how they may be measured. The importance of this stage cannot be over-emphasised for it is here that the real not the perceived problem should be identified. If the problem is relatively complex and/or a large number of factors are involved then this part of the procedure could consume a disproportionate share of the available time and resources.

The second step, conceptualisation, incorporates in part a data gathering exercise; in particular the data required according to the variables identified in the first stage. It is here that the possible and probable alternatives or options are outlined in conjunction with the data gathering procedure. An element of choice or judgement becomes necessary because often the data required is not available, or if available is in a form unsuitable for planning purposes. Thus decisions are necessary about the time and resources to be spent on data collection bearing in mind that the critical task is determining when enough data is available to conduct an analysis of the problem.

The third step is the design or model-building stage. The model enables each option or alternative to be assessed on the grounds of costs, performance and output. Although such models may be either simple or sophisticated, their value lies in their explanatory

function or capability and not in their complexity because models change according to the assumptions made about a problem and the data employed.

The fourth step, evaluation, is where conclusions are derived from the analysis. From these conclusions or observations, one particular alternative or course of action is identified. This alternative, generally regarded to be the preferred option, emerges out of an evaluation filtering process in which the initial range of options or alternatives are weighed according to a pre-determined set of criteria. At the same time as this set of known evaluation criteria are being applied there are other factors or constraints also impacting upon the process. Of these uncertainties, the political environment is possibly the most crucial because the political circumstances surrounding the selected option can largely determine its success or failure as a policy or plan.

The fifth and final step is implementation. It is at this level "that the chips are cashed". In other words, for a policy to be effective it must be implemented and for it to be implemented there must be agreement from those concerned that they are willing to not only support but also to work the policy. This commitment to the policy or plan can be garnered in a number of ways. Ideally this should be done by involving in the planning or policy-making process those individuals or groups who have the responsibility for providing the service. Thus for planning to have a successful outcome, it is necessary to secure the will and the compliance of the interested parties through the formulation of viable policies which will prove

attractive to these influential interest groups (Barnard, 1974; Lee and Mills, 1982).

The problem with any conceptual model of planning and policy-making is that it is not fool-proof. It does not come with an iron-clad guarantee that all one's planning or policy problems will be resolved through the application of the model. In essence it is people, or to be more precise, their particular values and perceptions and how they are applied, which make planning a success or failure, not the structure or mechanism to be followed. Thus a form of planning which places undue emphasis on the prescriptive aspects of the process is bound to create a degree or climate of frustration because it cannot deliver the anticipated changes. Earlier attempts at planning in the NHS has been severely criticised on precisely this ground (Royal Commission on the NHS, 1979; DHSS, 1980a). In reality, the ultimate outcome of planning is conditioned by the behaviour of individuals and groups at all levels in the process and each is largely driven by their own values and beliefs and not necessarily by a desire to achieve the common good. It is the conciliation of these conflicting views which the planning process seeks to facilitate, recognising however that "the question is not how planning can supplant the political process but whether and how it can fit into that process" (Lee and Mills, 1982, p. 55). These informed observers of planning in the NHS have developed this issue further by noting that "although planning does not, and cannot, seek to replace the political decision-making process it will, if successful, modify that process. And, equally, to be successful it must adapt to the political realities of decision-making" (Lee and Mills, 1982, p. 55-6). This presupposes

that planning is somehow an apolitical activity but as will be shown in Chapter Seven it is very much grounded in a political environment.

Planning Systems and Priority Services

The NHS planning system was seen as an enabling mechanism, one which would facilitate a more effective use of the scarce resources available for health care. The introduction of the NHS planning system coincided with increasing concern in the DHSS that the demand for health services was constantly outstripping the capacity of the NHS to meet it, and that the resources available for health care were not infinite. The response of the DHSS to this dilemma was the publication of a consultative document, Priorities for Health and Personal Social Services (DHSS 1976b) which was based on a series of programmes or range of services for certain groups. With considerable justification, the DHSS could claim that this was "the first time an attempt has been made to establish rational and systematic services" (DHSS 1976b). The reasons for the DHSS publishing their strategies for the future were fourfold:

i) that the responsibility for promoting certain services at the expense of others was one shared by the DHSS and the NHS;

ii) to indicate the changes in demand, both present and future, of different client groups;

iii) to highlight the areas where past neglect had led to serious deficiencies in health care; and,

iv) to promote the effective and efficient use of available resources.

The cornerstone of the proposals contained in the document was the concept that an appropriate standard of service should be maintained, in the light of unknown and expected resource constraints.

Together, the documents on priorities and the simultaneous introduction of the NHS planning system were an attempt by the DHSS to break away from the historically capital-led development of the health service and to "put people before buildings". It was widely assumed that, by establishing in the NHS a standard procedure for health service planning, based upon the twin concepts of rationality and comprehensiveness, services could be provided according to the 'needs' of the population.

The reaction from within the NHS to the priorities identified was very mixed, ranging from warm acceptance to out-right rejection. Such was the outcry from certain vested (medical) interests within the health sector that the follow-up publication - The Way Forward (DHSS 1977a) - contained a more pragmatic approach not only on the question of priorities but also on the issue of standards of service. As Klein has pointed out, "The Way Forward is strong on exhortation (but) it is singularly weak on suggestions about how to bring about the hoped for economies" (1977, p. 1096). There is a basic and fundamental issue at stake here - namely, the dilemma of imposing a national strategy whilst allowing local discretion. Insistence on a national strategy, for example, could mean that in some places improvements may be incompatible with local circumstances. Whereas, if the strategy is considered a desirable but non-binding level of service, there is the

risk that a continuing debate over priorites will overshadow any meaningful discussion on service improvements.

The resolution of these two major issues presents the DHSS with a basic and fundamental problem - the dilemma of ensuring adherence to a degree of local discretion in determining how the strategy should be implemented. The difficulties facing the DHSS can be spelled out in the following manner: insistence on a fairly rigid interpretation of national policy could mean that changes occur in some localities which could be deemed to be inappropriate or incompatible with prevailing local circumstances. However, if national policies are seen as desirable but non-binding, there is the danger that they will become meaningless and empty exhortations to health authorities to do better.

The Changing Face of NHS Planning

By the late 1970s it was apparent to the majority of NHS planners and decision-makers that the NHS planning system was not working. The very reason for the introduction of a formal planning system - to instil a sense of rationality and comprehensiveness into NHS decision-making - was ironically the very reason proffered for its failure (Royal Commission, 1979; DHSS, 1980a).

The reasons for the failure of the NHS planning system introduced with considerable fanfare in 1976 have been discussed already in Chapter One (p.3-5) and therefore need not be considered at length here. What is necessary, however is to headline the major criticisms of planning as these are germane to the following discussion of the

changes introduced, subsequently to NHS planning. Thus to re-iterate, the rational, comprehensive mode of planning was held to be unsuitable for the NHS on the following grounds: firstly, the prescriptive nature of the planning process tended to overshadow any attempts to broaden-out policy formulation (Barnard, et al, 1979; 1980a; 1980b); secondly, NHS decision-making was (and still is) largely incremental which frustrated most attempts to introduce rational order (Irving, et al, 1981; McNaught, 1981); thirdly, pressure to adhere to a strict planning timetable thwarted most efforts to evaluate those policies which planners succeeded in implementing (Barnard, et al, 1979; 1980a; 1980b); and finally, planning as an activity was seen as being rather separate from management and consequently the task or responsibility was often delegated to relatively junior staff within the organisation (Barnard, et al 1979; 1980; Weller and Williams, 1982).

The new Conservative government moved quickly to establish its position by publishing a series of discussion documents of which Patients First (DHSS 1980a) created the greatest impact. The outcome of these were proposals for re-structuring the management system of the NHS. The plank of the proposed changes was that one tier of management, the AHAs, should be abolished and their responsibilities devolved to new DHAs (DHSS 1980a). The proposed changes were ratified in July 1980 and the timetable for the changeover from AHAs to DHAs was fixed for 1st April 1982.

Central to the government's view on the NHS was the "profound belief that the needs of patients must be paramount" (DHSS, 1980a, p. 4): a re-affirmation of the philosophy underpinning the 1974 reorganisation.

The means for achieving this objective, in the government's opinion, was to have the decision-making process as close to the local community as possible so that the views of those within the community plus those providing direct patient care could figure prominantly in the decisions reached.

Consumer participation in the decision-making process in the NHS prior to 1974 was not very strong and along with the desire to develop health care commensurate with the needs of people it was decided to give the consumer a voice through the medium of CHCs. Briefly, CHCs had a responsibility to represent the interests of the public in the health service. There was, on average, one CHC for each AHA (and later one for each DHA) and there were reasonable clear criteria established which governed the relationship between these two bodies (DHSS, 1975). Specifically all health authorities were required to consult with CHCs, as well as others, with regard to any policy changes in services delivery.

CHCs, as an innovative concept, had problems in establishing their credibility with the NHS. Many NHS personnel view the need to consult on policy issues as an unnecessary and time consuming task and argued that CHCs therefore had outlived their usefulness (Royal Commission, 1979). Even Patients First, while acknowledging that CHCs had played a useful role, questioned whether there was a need for them now that decision-making was to be brought more closely in touch with the needs of the community, (DHSS 1980a). Despite these threats to their viability, CHCs are still very much in existence, as it would appear that the devolvement of decision-making to the local level has

not negated the role of the CHC as a representative of the consumer of health care. One could comment that bringing the management function closer to the point of delivery of the service does not necessarily mean that those who receive or use the services provided are any more likely to be involved in decisions pertaining to those services than hitherto. The ability of the CHC to influence the policy-making process is considered in more detail in Chapter Eight, in the light of what was learned from the study.

A 'New Look' Planning System

It is argued above that NHS planning had become bogged down in a quagmire of paper with the net result that very few plans were ever implemented. And if they were, the policies or programmes which were implemented seemed to bear little resemblance to that originally put forward. In short, planning was judged to have become both "stilted and stultified" (DHSS 1980a). Against this background, it was decided that the NHS planning system would benefit from major surgery which emphasised the strategic or long-term elements of planning (DHSS, 1982). The decision to modify the 1976 planning system embodied a tacit admission by the DHSS that a rational, comprehensive model of decision-making, while highly desirable was manifestly unworkable in the NHS. This was the main message contained in Barnard, et al's (1979) report of their investigation into the NHS planning system and accompanying this message was the recommendation that the planning system would benefit from a structural change that would acknowledge and incorporate the inherent tendency of incremental decision-making in the NHS. In short, Barnard and his colleagues

were advocating the adoption of a version of the 'mixed-scanning' approach to planning. Mixed scanning was a term coined by Etzioni (1967) to describe a planning methodology which recognised that both the rational and the incremental modes had particular attributes which were important to retain. In essence, Etzioni was arguing that elements of the rational model, specifically its attention to detail, are a necessary discipline for planners but instead of a comprehensive detailed examination of all issues, the emphasis should be directed towards the immediate. Incrementalism would be applied to those areas or issues considered to be of lesser importance, as a form of 'truncated' review, whereby the issues would be kept under surveillance and changes made as and when necessary. An issue would move from the overview to the detail stage and vice versa as values and priorites changed.

The revised planning system introduced in early 1982 eschewed the use of labels such as 'rational', 'comprehensive', 'incremental' and 'mixed-scanning', nonetheless, it is quite clear from the changes being implemented that the advice of Barnard and his co-researchers had had a profound impact upon the central planners of the DHSS. This is readily apparent by the fact that the revised planning system consisted of three elements: the strategic plan; the annual programme; and annual planning review (DHSS, 1982). Of these three elements, the strategic plan was considered to be the most important with the others regarded as subordinate in the sense that the annual programme and annual planning review are considered to be the mechanisms by which the policies embodied in the strategic plan are implemented.

The relationship between these three elements of the revised NHS planning system is depicted by figure 4.3. Health plans are now produced on two levels. Firstly each DHA is required to prepare a strategic plan covering a ten year planning period. In addition each DHA must produce a short-term (two year) programme which describes the steps that will be taken towards the implementation of national and local policies delineated in the strategic plan (DHSS, 1982; 1984). The second level of activity occurs at the RHA. Each RHA is responsible for preparing a Region-wide strategic plan that draws together the strategic plans from the DHAs within its boundary. Prior to this task, however, each RHA must prepare and circulate to its DHAs an outline strategy which identifies those issues seen within the RHA as being of particular concern and warranting specific consideration. These outline strategies must be approved centrally after which they become the cornerstone upon which each DHA prepares and constructs its strategic plan.

The final step in the planning process requires each Regional strategic plan to be submitted to the DHSS. In this manner the DHSS is able to construct a composite picture of the degree of adherence to national policies and to identify any deviance from established targets. This so-called 'top-down, bottom-up' approach to planning is justified on the grounds that "it provides the opportunity for the Government's policies and priorities to be reconciled with available resources (while) it also enables health authorities to appraise systematically their own services and to influence the Government" (DHSS, 1980a, p. 18). Thus, through resource distribution and indications of national priorities the DHSS imposes its views on RHAs,

Figure 4.3
The Revised NHS Planning System - Tasks and Responsibilities

	STRATEGIC PLANNING	ANNUAL PROGRAMMING	ANNUAL PLANNING REVIEW
REGIONAL HEALTH AUTHORITIES	* Outline Guidance Issues to DHAs - broad policies and priorities on service by service basis - revenue, capital manpower and work-load assumptions - comment on regionally managed services and DHA shared services * Amalgamate District Strategic Plans into Region-wide Document	* Issue Guidance to DHAs on Resource Assumptions and DHA-specific Targets * Region Managed Services	* Compare DHAs Progress and Proposals with the Agreed Strategy * Assess DHA's Standard of performance
DISTRICT HEALTH AUTHORITIES	* Commentary on Existing Services in District * Concise Service by Service Plans * Commentary on Major Deficiencies or Imbalances. * Financial and Manpower Assumptions Stated * Agreed Strategic Document Forwarded to RHA	* Operational Programme - developments and changes in financial year - minor capital works - revenue budget - joint finance expenditure * Forward Programme - comment on service developments - priority list of planning proposals	* Prepare Statement on Progress for Discussion with RHA

Source: Health Services Development - the NHS Planning System, HC(82)6, Department of Health and Social Security, March 1982.

who then redraw such issues for their own context and set the parameters for District plans. Each DHA considers its own priorites and needs through planning teams, which are then channelled up the system. And so the cycle continues.

This chapter sought to trace, albeit very briefly, the backgound to the creation and introduction of a formal planning system in the NHS, the transformation that the system underwent when the original concept founded on the twin pillars of rationality and comprehensive was judged inappropriate. The changes described herein occured during and after the fieldwork for the research was undertaken, however, it is unlikely that the alteration to the planning system of a procedural nature will necessarily have a major impact upon those charged with planning responsiblities since the context within which planners plan is largely independent of the structure or process employed. This is a view which is shared by many of the informed observers of planning and policy-making in the NHS (Haywood and Alaszewski, 1980; Ham, 1981; Lee and Mills, 1982; Glennerster, et al, 1983; Rodwin, 1984) and it is also a central issue of particular concern in this thesis.

The narrative so far has dealt largely with background material and the theoretical and conceptual framework within which this study of planning and policy-making in the NHS has been conducted. The next chapters, which form the body of the thesis, set out to attempt to answer the questions posed in the Introduction to the study. The issues under investigation in the following chapters are the interaction that occurred between planners, providers, and policy-makers charged with the responsibility of bringing a range of health

care services and facilities to an urban population, and the way in which NHS planning, as originally conceived and latterly amended, has had an effect upon the sequence of events which unfolded. However, before getting to the substance of the thesis, it is first necessary to describe in some detail the manner in which health services planning was conducted in the study area. The background to planning in NHA and the chronological sequence of events which occurred within the planning framework are recounted in Chapter Five.

CHAPTER FIVE

HEALTH PLANNING AND POLICY-MAKING - THE PRACTICAL MANIFESTATIONS

Health services planning as was noted earlier in Chapter One has been a relatively recent acquirement in the NHS. Although the discussion centred on the reasons which underpinned the introduction into the NHS of a formal planning system, little insight was offered as to the manner in which health authorities undertook the task of translating theory into practice. It is the practical manifestations of the NHS planning system which is the concern of this chapter. It describes in general terms the approach adopted by Newcastle Health Authority (NHA) in setting up the planning function in the light of DHSS guidance. It goes on to examine the workings of the planning system in some detail through an appraisal in particular of health services planning as applied to two particular groups; the elderly and the mentally handicapped. It concludes with a brief outline of a number of hypotheses which appear to effect planning and policy-making, each of which will be the subject of considerable analysis in later chapters.

An integral feature of the NHS planning system was its emphasis upon the 'health care group', thus recognising that there were certain groups or populations in society whose particular needs or demands for health care often encompassed much of the totality of care available. "In practice the health care needs of the community are highly diverse and a single individual or family may simultaneously require health care for several different conditions . . . (therefore) it is useful for planning purposes to distinguish a limited number of broad

'health care groups' with special needs and to differentiate some categories of care . . . so as to quantify the services required" so stated the DHSS in its justification for introducing structural changes in the NHS (DHSS, 1972 p.51). This focus on health care groups as a cornerstone of NHS planning was reinforced by the publication of a consultative document 'Priorities for Health and Personal Social Services' (DHSS, 1976b) which mapped out the national priorities according to the care group approach. The virtually simultaneous publication in 1976 of the NHS planning system manual and the Priorities document ensured that the structure of planning in the NHS focussed upon care groups rather than on facilities and services, per se.

The effective application of the NHS planning system was based on two fundamental characteristics; operational or short-term planning, and strategic or long range planning. The former encapsulated the procedures through which the health authority intended to carry out agreed policy changes by documenting those activities which it believed it could implement in the short term. The latter was the health authority's statement in outline form of the sort of heatlh care policies which it wished to develop in the future. Thus strategic planning set the policy agenda for health care and operational planning stated the necessary steps needed to achieve or implement the policy.

The manual which accompanied the introduction of the NHS planning system urged that planning should be a multi-disciplinary activity

incorporating, where feasible, all those who were involved with the delivery of health care.

The vehicle for administering this multi-disciplinary approach to planning was the 'health care planning team' (HCPT). Its role and purpose was to consider the health care needs of a particular group or population and to put forward proposals and/or policies designed to 'improve' the accessibility, quality and quantity of care available to that group. The difficulty with this approach was that the focus of the HCPT was largely insular - considering the health care implications only of the issues confronting them - whereas it is well known that many of the so-called 'health problems' facing society are beyond the capability of the health sector to overcome and command the attention of a large array of bodies and agencies if any progress is to be made (Carter and Peel, 1976, DHSS, 1980a).

The tendency for health authorities to look inward was recognised early on by the DHSS who issued guidance which recommended a form of joint planning between health and local authorities as being most appropriate given the well-known overlap or complementarities of responsibilities between authorities which existed and would continue to do so (DHSS, 1976c; 1977b). These joint planning teams (JPT), or joint care planning teams (JCPT) as they were sometimes called, were multi-disciplinary in composition and care group oriented.

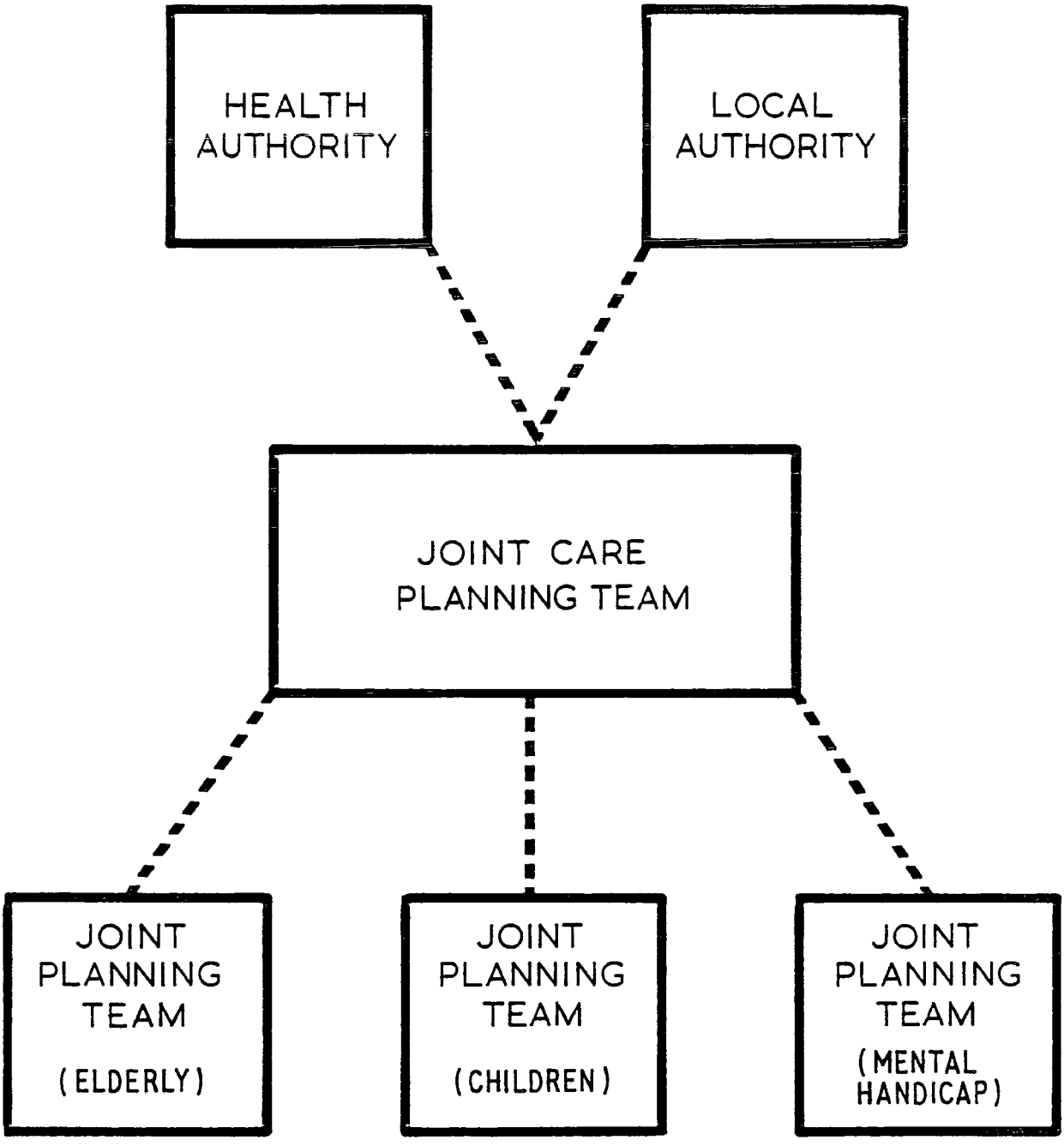
Health Services Planning in Newcastle

NHA, in line with most health authorities in England and Wales,

followed the recommendations embodied in the NHS planning system manual (DHSS, 1976a) and established multi-disciplinary HCPTs on a care group basis, in line with those identified in the Priorities document (DHSS, 1976b). With the issuance of the guidance from the DHSS pertaining to joint care planning, NHA amended its existing planning arrangements of HCPTs and replaced them with five JPTs for each of the client groups of complementary health and local authority services, viz the elderly, the mentally ill, the physically handicapped, and children and families with children. At the same time that the decision was made to move from HCPTs to JPTs, the health authority also established an overarching JCPT (figure 5.1). The JCPT, composed of senior officers and professionals from both the health and local authority, was the principle planning body for the two authorities. Its chief functions were as co-ordinator and facilitator. Its co-ordinating role was to oversee the activities of the JPTs which were in reality sub-groups of the parent JCPT. The JPTs were responsible for the formulation of operational planning proposals as well as the preparation of strategic or longer term policies, which were then channeled through the JCPT for scrutiny and modification (as appropriate) before being passed to the respective authorities for endorsement and ratification or rejection.

The facilitating role of the JCPT was to channel policy matters to the various JPTs for their consideration in the light of their collective expertise and knowledge. Because the JPTs were sub-groups of the JCPT, they necessarily had to report to the JCPT on a periodic basis what progress was being made on the issues before them. The JCPT was

Figure 5.1. THE JOINT CARE PLANNING STRUCTURE



---- *Indicates advisory relationship*

thus able to be kept informed of the continuing activites of each JPT and was also in a position to steer or influence, as appropriate, the direction - policy wise - in which each JPT was heading.

The JCPT, however, had one particular responsibility over and above that of its relationship to the JPTs and that was its concern with the allocation and distribution of joint finance monies. It was the JCPT which decided how the monies should be allocated, to whom, for what project or proposal and for how long. Usually a particular joint finance programme was drawn up by the JCPT for the current financial year and this was agreed by the appropriate JPTs as not all were or would be in receipt of joint finance monies.

This then was the framework or environment within which planning in NHA occurred. The balance of this chapter is concerned with how these planning teams operated in practice. This will be articulated through a consideration of the events which befell two JPTs - the elderly and the mentally handicapped. The investigation of the workings of these two JPTs was largely confined to their strategic or policy-making activities rather than their operational responsibilities as it was the former which were of particular concern. Each of the selected health care groups is examined in turn, and the sequence of events which were fundamental to the emergence of policy initiatives and their outcome is traced chronologically.

Services for the Elderly

Early on in its planning history NHA moved from HCPT to joint planning

teams as advocated in the DHSS circular HC(77)17/LAC(77)10 Joint Care Planning: Health and Local Authorities (DHSS, 1977b) and consequently a joint planning team for the elderly (JPTE) was established which held its first meeting in July 1977. Its early record was largely undistinguished and its sole cause célebre was to press for more in-patient accommodation (hospital beds) for the elderly. The team originally met on a monthly basis but by the end of 1978 it met very infrequently (10 times over the period 1979-1981) and appeared to have a knack for running into controversy. Figure 5.2. shows the major sequence of events of the JPTE over the research period.

The strike by Social Workers occurring at the end of 1978 and lasting until early 1979 resulted in cancellation of all JPTE meetings until the dispute was resolved, as the social worker members of the team refused to participate in any meetings on behalf of the local authority until their grievances were resolved.

DHSS circular HN(79)35 A Programme for Improving Geriatric Care in Hospital (DHSS, 1979) countenanced the introduction of measures designed to bring about changes in the attitudes of staff working with the elderly (in particular, hospital staff) to one considered to be more sympathetic towards the elderly. In other words, the document was placing considerable emphasis on the twin concepts of 'care' and 'caring'. This circular caused some conflict within the JPTE primarily because the health authority's Personnel Officer believed that it should be given preferential treatment and that a training programme should be prepared forthwith. Others counselled that a

Figure 5.2

Services for the Elderly: sequence of events

977	* joint planning team established * infrequent meetings and when held only discussed possible effects of national policies.	
979	* no JPT meetings, social workers strike. * discusses implications of DHSS circular on nurse training.	* Policy Group for the Elderly put forward. Proposals for the future development of services for the elderly involving Hospital A and Hospital B. * RHA questions. Basis of proposals for future services for the elderly, especially the Walkergate Project.
	FIELDWORK BEGUN	
980	* new chair for JPT but still in medical hands. * infrequent meetings due to lack of business.	* series of discussions between NHA and RHA over strategy for the elderly.
981	* research proposal from local GP, discussed by JPT and referred for more details. * report from Joint Working Group on housing considered by JPT.	* Medics enter debate over services for the elderly and question Walkergate Project. * medics draw in CHC in local MPs. * RHA agrees to support some of proposals but not Walkergate option. * Walkergate project deferred pending feasibility study. * discussion on configuration of beds for the elderly in Hospitals R, F and N.
982	* JPT began to look more closely at local issues but still only met infrequently.	* agreed protocol reached for beds for elderly but when proposals published some backtracking occurred. * Forum for the Elderly - public meeting held.
983	* copy of joint strategy received for consideration.	* Joint Strategy for the Elderly - a consultative document published.

New planning arrangements for NHA under consideration. Proposal to devolve planning down to Unit (Hospital) level is major change which would mean demise of both the JPTE and PGE.

more low key approach should be adopted and that the circular should be placed in context with all other issues confronting the JPTE.

This difference of opinion was apparently unresolved, however it did cease to be an issue in the sense that it no longer appeared as an agenda item for the JPTE after mid-1980. This change could, in part, be attributed to the fact that a new chairman was appointed to the JPTE who seemed to have a different opinion on how it should be organised and what issues should come before it. The attention of the JPTE shifted from the concern over 'beds' to a consideration of the merits of 'half way' houses for elderly patients who no longer required normal hospital-type care. As with the 'beds' issue 'half-way' houses became the major concern of the JPTE however this time it took the relatively bold step of setting up a Joint Working Group (JWG), incorporating health, housing and social service personnel to look into specialist housing for the elderly. A report was prepared by the JWG and discussed at the July 1981 meeting of the JPT(E), although no policy initiatives or proposals emerged which were forwarded to the parent bodies for consideration.

Although the JPTE was considered by NHA to be the forum for policy-making and planning, the lack of progress achieved by this body was of major concern to the planners and administrators employed by NHA. So concerned was this group of NHA planners and administrators that they created their own Policy Group for the Elderly (PGE) as a means of taking things forward. It should be noted that some members of the PGE were also members of the JPTE. It would appear that the 'real' planning was done by the PGE with the consequence that the JPTE became

essentially a forum for discussion and therefore largely ceremonial as none of the key issues exercising the PGE did not appear to have been forwarded to the JPTE for their considered response.

The major activity of the PGE was the articulation of a strategic policy for the elderly in NHA. There were two related issues of concern; a shortage of acute and long-stay hospital-type accommodation amounting to some 148 beds; and a lack of psychiatric services for the elderly especially beds on the general hospital site in accordance with DHSS policy. Two related proposals were put forward by the PGE for resolving these problems. These were, firstly, the opening of long-stay/rehabilitation beds for the elderly at Hospital A (currently 'moth-balled') which could be accomplished fairly quickly and, secondly, the closure and subsequent redevelopment of Hospital B to provide a range of facilities, including local authority services. This latter was clearly a long term proposition which would have major implications for both the health and local authorities. The PGE believed that this proposal for the redevelopment of Hospital B provided a unique approach to joint planning by considering more innovative ways of providing services for the elderly.

In accordance with established procedure, NHA put the proposals out to consultation to all those considered to have an opinion on their endorsement. The proposals, as might be expected, came under close scrutiny from a number of sources, but surprisingly not from the JPTE. On the one hand a number of hospital consultants questioned the wisdom of these proposals and in particular, a consultant psychiatrist was especially disturbed by the Scheme for Hospital A

and expressed concern at the apparent lack of support for more beds for the elderly severely mentally infirm (ESMI). His solution was to suggest the creation of an ESMI unit at a different hospital. The Regional Health Authority, on the other hand, was more concerned with the proposal to re-develop Hospital B; it disputed the financial cost involved and doubted whether it would become available and also raised questions regarding potential staffing problems of the scheme. In short, the RHA was challenging the viability of the Hospital B scheme, as is its right in accord with its overall responsibilities. However, a cynic would argue that their zealousness in this instance could well have been influenced by the fact that Hospital B was where the RHA's administrative headquarters was located and the proposed redevelopment of the Hospital appeared to jeopardise the continuation of this arrangement.

The picture became even more complicated when the Local Medical Committee (LMC) also expressed concern about the feasibility of Hospital B scheme, arguing that action was needed now not in the future. In response to this comment the chief officer of NHA cited recruitment difficulties, especially of nurses, as the main reason for the delay in implementing any short-term measures.

The pressure on NHA to take some action was increased when two clinicians enlisted the aid of the Community Health Council (CHC) to press for more acute beds in the General Hospital - part of which had remained unopened because of staff problems - as an extension of the service currently provided at Hospital B instead of the proposed re-development. A third clinician, not content with the efforts of the

RHA, CHC and LMC, wrote to his Local Member of Parliament (MP) and a neighbouring MP (who passed a copy of the correspondence to the Minister of Health) deploring the current shortage of beds. He suggested that the re-development of Hospital B was unnecessary because of unopened beds elsewhere and alleged that the whole service was in danger of an imminent collapse. The response of the chairman of NHA to these critics was to re-affirm that the policies outlined by the PGE were considered to be the most appropriate strategy. Indeed the NHA in an attempt to move forward wrote to the RHA asking it to sanction an increase of 25 acute beds for the elderly in the general hospital along with approval for both Hospital A and Hospital B schemes. After a considerable lapse of time the RHA agreed to the request, with the exception of the proposal for Hospital B which it still considered to be inappropriate and/or unnecessary.

The position regarding Hospital B remained deadlocked with pressure continuing to mount on the NHA to do something immediately. The PGE however was adamant that the key to improved services for the elderly lay with the scheme for Hospital B. Indeed so committed were they to the scheme that they attempted to husband financial resources for it by reallocating a small portion of NHA's recurring revenue budget to the project, with the monies being employed in the short term to finance projects with non-recurring resource implications. Such projects tended to be one-off capital (building) schemes or purchase of supplies and/or equipment.

Whilst the PGE was trying to generate the necessary financial resources to underwrite the project, a number of original supporters

of the scheme for Hospital B began to express doubts about its feasibility. By June 1980 it became apparent that an appraisal of this and other related proposals was warranted, and after discussion with the clinical and other staff involved, a view emerged that what was required was a far more imaginative approach to the care of the elderly than had been hitherto postulated. Consequently, a feasibility study of the Hospital B strategy was undertaken, with the express purpose of clarifying the policy first before commencing any of the design work.

The outcome of the feasibility study was a report concluding that the initial scheme proposed for Hospital B was unrealistic and inconsistent with current thinking on care of the elderly. Concern was expressed that the concept of care originally envisaged might be counterproductive if it meant cloistering elderly people away from society. The project was reassessed within the conventional wisdom that elderly people should be able to maintain as independent a life as possible and the facilities of NHA and the local authority should be marshalled accordingly. It is interesting to note that this reappraisal of part of the strategy for services for the elderly occurred quite independently of the JPTE, whose energies still appeared to be concentrated on matters more operational than strategic in nature.

Concurrent with the difficulties being experienced by the PGE in its efforts to affect a strategy for the elderly in NHA, the JPTE began to evolve a more assertive role for itself by turning its attention to issues of distinct local relevance. In the main, the local issues

considered by the JPTE could be classified under two headings: operational and research.

Under the 'operational' banner, the JPTE considered such matters as staffing needs for the professions supplementary to medicine (for example, chiropody, speech therapy); a carers support scheme whose aim was to provide assistance and relief to families caring for elderly relatives; a consideration of the use of 'check lists' for health visitors, and in particular for new staff, to help identify the 'needs' of the elderly patient; and discussion of the problem of providing adequate ambulance facilities in an under-served area of NHA. From the evidence available it would seem that the role of the JPTE in discussing these operational issues was to offer advice to its parent body the JCPT or to the Management Team of NHA, on the priority which each of these issues should enjoy relevant to the overall list of demands upon NHA's resources.

Not surprisingly the number of items for consideration under the 'research' label was small; in fact only one proposal was discussed. This was a project to evaluate the needs of older people within a general medical practice. The research was to focus on identifying the clinical, social and psychological needs of the elderly population in general practice in a particular area of the city and would require five years to complete. The proposal received initial support from the JPTE subject to the preparation, with costs of a more detailed research protocol. A revised proposal was duly submitted which satisfied the JPTE as to its acceptability and the JPTE agreed to support the research and recommended that the JPCT should make

available the necessary funds. The recommendation was accepted by the JCPT. The research project has had a troubled existence since it was approved and supported by the JPTE in June 1982. A difference of opinion arose between the general practitioner (GP) who instigated the project and the research staff employed by NHA to undertake the research. This difference of opinion was essentially over the research protocol and focus. The researchers sought a more active role in the project whereas the GP wished to retain complete control over the manner in which the research developed. By the time the research field work was completed (August 1984) there was considerable uncertainty over the future of the project because of the GP's decision to sack the researchers. This led to the financial support for the project being reconsidered in the light of these events. It does appear that the irreconcilable split between the GP and the research staff effectively led to a withdrawal of funding for the scheme.

Despite the efforts of the JPTE to take a more active role in planning by turning their attention to so-called 'local' issues, it was the PGE who de facto remained the principal policy-making body for the elderly in NHA. However, even the best efforts of the 'experts' often go awry as the furor over the Hospital B project has demonstrated.

As is often the case in planning and policy-making, another issue arose at the same time as the PGE was attempting to salvage something of the Hospital B proposal which threatened to shipwreck the carefully prepared plans of the PGE. This was the immediate, and potentially disruptive problem of the distribution of beds for the elderly between

the three general hospitals of NHA. This issue was of sufficient importance to side-track the PGE from its concern over the Hospital B scheme, not least because of the long term implications of the bed distribution issue which if unresolved could jeopardise any agreed policy proposals for the elderly.

The distribution of the beds for the elderly in NHA has to some extent always been an underlying problem generally because of the apparent shortfall between the number of beds required according to DHSS norms and those currently available, and its transformation into a critical issue occurred during the winter of 1981-82. This was a particularly severe winter which saw a great many elderly patients admitted to hospital for a variety of ailments. It is a commonplace that during the winter months more elderly are admitted to hospital than at other times of the year. What was unusual about the winter of 1981-82 was the scale of admission; so many were admitted that beds in other specialties within the hospitals had to be found for these elderly patients. Not surprisingly perhaps, this caused considerable disquiet amongst the clinical staff of the hospitals concerned who found their beds 'blocked' by these elderly patients. They were blocked in the sense that there was nowhere that these elderly patients could be transferred to and thus free the bed for use as originally specified. For a more detailed discussion of the blocked bed see Hall and Bytheway (1982).

This matter was further complicated by the fact that one particular hospital (Hospital R) treats many more elderly patients than the other two hospitals (Hospital F and Hospital N) but has no designated

Department of Geriatric Medicine providing hospital facilities and care specifically for the elderly, and therefore was unable to supply a comprehensive service. Pressure was brought to bear on NHA to produce a formula acceptable to all concerned for resolving this thorny issue. The task of 'pulling the rabbit out of the hat' was given the PGE. A variety of proposals were proffered none of which was particularly easy to implement and all had different advantages in that some were obviously short-term interim solutions whereas others were much more long-term in that it would take many months to implement.

Inspite of the agreed immediacy of the problem by all concerned, the proposals put forward by the PGE had a very mixed response particularly amongst the clinical staff with each clinician favouring the option which best suited themselves. After a series of protracted negotiations conducted over an eight month period an agreement of sorts was reached on an acceptable configuration of beds for the elderly in the three hospitals. The agreed conformation was Hospital F -50 beds, Hospital R - 50 beds and Hospital N - 80 beds. Unfortunately as might be expected this did not satisfy everyone. The geriatricians (clinicians whose major responsibility is the elderly patient) at Hospital C felt particularly aggrieved because this plan would see their bed complement fall from 80 to 50, which was not acceptable. They were not placated with the fact that this reduction in 30 beds was to be largely offset by opening an additional 25 beds for the elderly at Hospital N. Discussion is still continuing but progress has been slow with each hospital vigorously defending its own corner.

The demise of the Hospital B project resulting from the report of the feasibility study indicated to both NHA and the local authority that a complete re-appraisal of the level of care and need for services for the elderly in the City was warranted. The vehicle for achieving this objective was an open meeting or forum to which participants from all interested parties were invited. The purpose of the forum was twofold: firstly, to consider new ways of providing services for the elderly and; secondly, to impress upon those present that the specific needs of the elderly often transcend the facilities offered by the health and local authorities.

This proposal, initially mooted by the Director of Social Services, and referred to as a Joint Strategy for the Elderly was essentially a joint venture between the health and local authorities. It was the PGE of NHA, however which undertook to organise the forum by canvassing potential participants and seeking and inviting submissions for discussion at the forum. The forum sought to undertake three parallel objectives:

- to review the levels and balance of care provided by health and local authorities.
- to review the special arrangements for the elderly provided by such bodies/agencies as police, transport, housing, and so on.
- to review and consider the perceptions that the elderly themselves have of these agencies, the problems they face, and how best to respond.

The response to the letter of invitation sent to a variety of agencies was very good indeed, with the result that the forum was held in early

May 1982. A variety of issues were aired and even though nothing conclusive came out of the discussion, a considerable number of ideas meriting further study were put forward. The responsibility rested with the NHA and the local authority to keep this initiative alive by putting forward a number of proposals for services for the elderly which reflect the sense if not the nature of the discusssion of the Forum.

This responsibility was discharged with the publication of a document Joint Strategy for the Elderly (NHA, 1983) in which many of the ideas raised at the open meeting were incorporated, along with the presented papers. The document was distributed very widely within the city and comments were invited on the practicability or otherwise of the issues contained therein. The intention was, that out of this document and the ensuing consultation would emerge an outline strategy/policy for the elderly. Although the issue had gone to the JPTE, more out of courtesy rather than conviction, for its consideration and comment, it is interesting to note that by the end of August 1984 the consultation process was still in progress.

Whilst these local activities were engaging both the JPTE and the parallel body the PGE, government policy was still being propogated with the expectation that health authorities would respond accordingly. The reaction locally to such central initiatives often resulted in strained relations between the RHA who was seen as being the prolocuter for central policy and the health authorities which had to implement the policy. The following example will serve as an illustration.

Early in 1983 the Health Advisory Service of the NHS published The Rising Tide (HAS, 1983) a policy document on the development of services for mental illness in old age. The Report commented on the increase in the elderly population which has already occurred and the likely effect of future projected increases. It expressed dissatisfaction with the general level and standard of care provided for this group of people in the NHS and argued for a more informed, understanding and caring form of service for the future. In short the Report advocated a more positive and innovative approach for those elderly persons suffering from some form of psychiatric disorder. The DHSS when releasing the Report provided an opportunity of additional resources for selected innovative schemes for service provision for this group.

NHA in accordance with the advice contained in The Rising Tide and the regulations governing the special funds available, submitted a bid for monies to the RHA in support of a scheme. NHA was led to believe that their proposal was not acceptable but received no official explanation as to why this should be the case. This led some officers of NHA to express their dissatisfaction with the standard of planning and guidance which they received from the RHA. They particularly complained of lack of perception and understanding on the part of RHA of the problems facing NHA and felt that the advice they received was superficial in the extreme. In general the outcome was such that there now seems to be a cloud over-shadowing the relationship between NHA and the RHA. That this should happen is most unfortunate since the two agencies are not competitors but allies sharing a common goal.

By 1980 the DHSS in its wisdom decided that the planning system introduced and operated since 1974 was not living up to its initial expectations, that it had become bogged down in procedural issues and was overly bureaucractic and therefore that modifications were necessary (DHSS, 1980a). The publication of circular HC(82)6 Health Services Development - the NHS Planning System (DHSS, 1982) heralded the thinking within the DHSS on how the planning system should be restructured. The essence of DHSS reasoning was that planning teams had out-lived their usefulness and should be disbanded. This was a view which commanded considerable support within the NHA and although the JPTE was still functioning it was clear by August 1984 that its future was very much in doubt. This was primarily because the overall responsibility for service planning was under review and the perceived wisdom in NHA was that this responsibility should be devolved from the PGE and JPTE to the new Unit (Hospital) Management on the grounds that this would bring the planning and policy-making processes closer to those who are providing the services.

To a certain extent, the JPTE was partly to blame for the rise of voices within NHA which were critical of planning in general and planning teams in particular. This was because the JPTE seemed to be very uncertain as to what its role and responsibilities should be, it displayed a lack of initiative, its leadership seemed poor and also it appeared to seek an 'easy life' through an avoidance of those issues which might be considered to be difficult or contentious. In summary, the performance of the JPTE provided the ammunition sought by those in NHA who were strongly advocating a review of planning and the policy-making process.

The apparent failure of the JPTE to take the planning bit between its teeth led to its supplantation by the PGE who took upon themselves the planning role. The reasons why the JPTE should behave as it did and the role played by some members of the PGE are in part the subjects of Chapters Six to Nine of the thesis. However, before beginning a discussion on the implications of the machinations of the JPTE and the PGE it is first necessary to compare and contrast the planning of services for the elderly with the events and activities relevant to the second planning area under observation, services for the mentally handicapped.

Services for the Mentally Handicapped

The joint planning team for the mentally handicapped (JPTMH) was the first joint planning team to be established (April 1977) in the locality under the auspices of the 1977 Joint Care Planning circular (DHSS, 1977b), and it differed from the JPTE in one significant respect in that it also included representatives from an adjacent health authority which provided on a 'subcontracted' basis all inpatient care for mentally handicapped persons from the study area. Figure 5.3 shows the historical pattern of events for the JPTMH. From the outset the JPTMH concerned itself solely with policy issues and the planning of the services acccording to declared policies. As there were no hospital-based facilities in NHA for the mentally handicapped, the planning team was not hindered by the existence, organisation, and usage of current facilities. In other words, its room for manoeuvre was largely unrestricted.

Figure 5.3

Services for the Mentally Handicapped: sequence of events

7 * Joint planning team established, regular meetings but very little in policy or plans emerged, discussion generally dealt with documents produced by the National Development Team for the Mentally Handicapped.

FIELDWORK BEGUN

0 * CHC letter to Minister of Health
* DHA given directive to prepare policy for mentally handicapped.

1 * Blueprint for mentally handicapped.

* JPT replaced by Mental Handicap Management Partnership.
* CHC secretary seconded as interim secretary for partnership.
* CHC and voluntary agencies seek and get equal representation.
* DHA allocates £100,000 to Partnership.
* Psychiatrists voice concern over role of Partnership.

2

* Request to use monies to bolster nursing support for community psychiatric team.
* Acting secretary expresses wish to return to CHC.
* Local Authority unwilling to take responsibility for post of Partnership secretary - DHA does instead.
* Partnership agrees that Family Resource Centre major priority.
* DHA approve use of hospitals as base for Resource Centre.
* Proposal for strengthening and expanding Community Mental Health Team before DHA.
* Partnership secretary appointed as part of DHA management compliment.

3 Proposal under consideration to devolve planning to Unit (Hospital) level. If agreed would not effect Partnership which would continue.

The first task undertaken by the JPTMH was to determine the precise numbers of mentally handicapped people, both children and adults, within the NHA. The Social Services Department for the corresponding local authority suggested that some consideration should be given to a policy on future building requirements and the type of client such buildings would be expected to cater for. The result was a consultative paper prepared for the JPTMH and published in October 1977 which outlined the proposed development of services for the mentally handicapped. This strategy for the mentally handicappped was given reasonable circulation and comments were invited by the JPTMH. The strategy, duly amended in the light of the commments received, was incorporated into the NHA's strategic plan.

The perusal of the relevant records suggested that little of importance was discussed by the JPTMH after this initial flurry of activity other than considering the various reports and papers issued by the DHSS on behalf of the Development Team for the Mentally Handicapped - a national advisory body, established by the DHSS, whose task was essentially to raise the consciousness of the NHS to the plight of mentally handicapped patients. In short, the JPTMH was relatively dormant for a period of about two years, until early 1980 when it began to consider a specific proposal for two small residential homes, each to contain five places for severely mentally handicapped children. However, the need for these units was questioned by the JCPT on the grounds of the financial commitment necessary, and that there were other, and more worthy, competing demands.

It was during the debate on this issue that a number of events occurred which ultimately resulted in the dissolution of the JPTMH by the JCPT. The JCPT decided to assume resonsibility for the duties of the JPTMH on the grounds that it had become moribund and that, therefore, a new initiative was required. This new initiative was ultimately to emerge in the form of a partnership between NHA and the local authority, with a specific remit to implement an agreed policy, for the mentally handicapped. The sequence of events which precipitated this dramatic change are outlined in the following paragraphs.

The Social Services Department's response to an earlier NHS strategy for the mentally handicappped was to place considerable emphasis upon community support for parents and families with handicapped members. At the same time a paper discussed by the JPTMH suggested that a particular unit, then being considered for closure, could be re-opened as a family support unit for parents of mentally handicapped children. The JPTMH's attention to these issues was diverted by an open letter, from the local CHC, to Dr Vaughan, then Minister of Health. In the letter, the CHC deplored the lack of provision for the mentally handicapped within the NHA and further criticised the NHA for not having a 'real' plan for future services. The letter concluded with an invitation to the Minister to enquire into this apparent lack of progress and poor state of affairs. The response of the NHA to the CHC's letter was to chide them for their lack of faith by saying that NHA believed that it was important to develop services in close co-operation with the local authority and that it was important that this be done properly and without undue haste. Indeed, the CHC were

reminded that they had been party to the discussions on a possible strategy for the mentally handicapped and also that the NHA had partly underwritten the cost of a study on mental handicap services that the CHC was conducting. The implied but unstated message to the CHC was that their activities could jeopardise the limited progress to date; progress that depended a great deal on the continuing goodwill of all parties involved.

In tandem with this activity, a number of proposals by the CHC, the local authority, NHA planners, psychiatrists and others were put to the JPTMH for consideration; proposals which, in one form or another, stressed the desirability of a community-based service. An element common to all of these various papers, proposals, and reports was the need for some form of support for families, such as a resource centre or similar unit providing counselling services, information and advice; a base for community staff; and some provision for short-term relief/day-care faciliites. The culmination of this activity was the publication of a report focussing upon the needs of mentally handicapped people and their families (NHA, 1981).

The report called for the establishment of a partnership/joint venture between representatives from the NHA, the local authority, and from the community (including parents of the mentally handicapped). The report was endorsed by all concerned and subsequently the Partnership superceded the JPTMH thus explicitly recognising that there were certain advantages to a jointly planned and operated service. The Partnership was to be a consortium of three officers and three members from the NHA and local authority, with two

places for community/voluntary groups. Not surprisingly, the local community/voluntary groups were not particularly happy about having only two places on the Partnership, since it could be argued that the odds tended to favour the statutory bodies; hence they pressed for equal status. Indeed, an agreement was reached which gave the consortium of community groups equal representation on the Partnership with the nominated members from the NHA and the local authority (Petfield, 1983).

Notwithstanding these teething problems, a start was made towards the establishment of the Resource Centre for the mentally handicapped by securing the agreement of the local CHC to the secondment of their secretary, as the interim manager for the Resource Centre.

The necessity to find a suitable location for the centre-piece of the Partnership - the Family Resource Centre - was the major task pre-occupying it in the early days. An extensive review was undertaken of potential NHA and local authority premises but none were considered to be suitable. Part of the NHA long range plan for hospital usage had identified spare capacity in Hospital S, which it duly earmarked as a future site for its headquarters as an alternative to the rented accommodation presently occupied. The Partnership became aware of this vacant space in Hospital S and a formal request was made to use this space earmarked as its future headquarters as the base for the Family Resource Centre. The request for the use of the space in Hospital S as the Family Resource Centre and to defer the transfer of NHA headquarter's was duly granted in June 1982 even though the cost to NHA was high as it was effectively foregoing a saving of some

£100,000 per annum which would have been achieved through the transfer. This courageous decision served to underline the degree of the commitment of NHA to the partnership scheme.

One of the early issues to arise and one which has proved difficult to resolve was the question of who held executive responsibility for the Partnership. This arose as some of the clinical and professional staff in NHA questioned the partnership's role and responsibility to determine the services and facilities necessary for the mentally handicapped. For example, a consultant psychiatrist was worried that responsibility for psychiatric services would be transferred to the Partnership whereas at present these services were hospital based and specifically under his control. The argument was essentially about professional prestige and accountability with this particular clinician demanding reassurance that his authority was not about to be undermined. He was assured by NHA that the responsibility for psychiatic services was not likely to become part of the Partnership's remit.

There arose also a difference of opinion between those officers in NHA with responsibility for personnel and the Partnership over who had the mandate and authority to decide the staffing requirements of the Partnership. This dispute originated when the Partnership decided, after considerable discussion, that the field staff required to form the nucleus of the community handicap team should be a clinical psychologist and some community nurses. The view of some of the professionals in the Partnership and in the NHA was that, in the first instance, the staff appointed should only be community nurses. This

potentially damaging situation was eventually resolved by the NHA itself who stated that the Partnership's constitution gave it the authority to decide its own staffing levels within the agreed financial sum set aside for the Partnership. The outcome was that the usual line relationship for staff would apply but the Partnership had overall responsibility for the policy under which staff would work and also how its £100,000 funding should be allocated. In summary, those working for the Partnership were considered employees of the health or local authority as the case may be but were ultimately accountable to the Partnership for their duties, and as such the onus was on the Partnership to draw up the necessary job description.

The Partnership was originally launched in June 1981 on an agreement which saw the secretary of the CHC accept the post as Partnership manager on a seconded basis for six months. Towards the end of the seconded period the Partnership manager expressed the wish to return to the CHC and it was agreed that a permanent manager should be appointed and that the post should be advertised. It had initially been agreed that the post would be a local authority appointment but that the salary for the position would be paid for by the NHA. The reason for this arrangement was to ensure that the post did not become part of the NHA management complement under the exercise to reduce management costs introduced simultaneously with the change in the structure of the NHS (DHSS, 1981). Unfortunately, and in spite of the support of the Social Services Department, the local authority's personnel department refused to sanction the scheme on the grade and salary level considered by the Partnership to be appropriate. The personnel department would only approve the scheme on a lower grade.

The NHA not unnaturally, considered this to be totally unacceptable, arguing that the higher grade was essential in order to attract the necessary calibre of candidate for the position. The local authority refused to alter its view and the NHA proceeded, unilaterally, and advertised the post as a health authority appointment on the grade originally agreed, even though it would have profound implications for the NHA as a result of the review of management costs being conducted by the DHSS (DHSS, 1981). This illustrates once again the degree of commitment of NHA to the Partnership and its determination that it should succeed. Such intransigence on the part of the local authority is difficult to understand as the financial cost of the post was being borne by the NHA. One could perhaps deduce from this that the local authority did not necessarily share the same commitment to the Partnership as NHA.

Despite the intention on the part of the NHA to appoint a permanent manager for the Partnership, the post was not filled until June 1983. The delay was due primarily to the reorganisation of the NHS which commenced in April 1982. Part of the restructuring was the decision to curtail and/or reduce the level of management in the NHS and consequently any new posts or changes in posts had to be formally approved by the RHA.

Concomitant with the approval of the NHA to base the Family Resource Centre at Hospital S, the NHA also agreed that the Community Psychiatric Service and the Community Chiropody Service should be transferred to the same location. Because considerable building work was necessary before the hospital could accommodate all of these

functions, it was thought unlikely that the Family Resource Centre as orignially proposed would be ready before August, 1984. However, an interim arrangement was reached and the Family Resource Centre began operations from Hospital S in October, 1982.

With the establishment of the Family Resource Centre, the next major issue for the Partnership was the creation of a Community Mental Handicap Team (CMHT). This has been a rather protracted process which, according to the first report "has been the subject of much discussion, involving 39 representations of the various professional interests over some 10 meetings" (NCC/NHA, 1982, p.5). However, the discussions have not been in vain as the core or nucleus of the Team has been identified and broadly consists of the following personnel:

Professional Adviser,

Occupational Therapist,

Educational Psychologist,

Teacher,

Doctor,

Clinical Psychologist,

Nurse,

Speech Therapist,

Parent,

Administrator,

Physiotherapist,

Pre-School Adviser,

Social Worker.

It was envisaged that some, but not necessarily all of the above, would be based at the Resource Centre. A request was sent to the NHA for the additional funding required for a modest start to be made to the CMHT. The funds were sought for 2 physiotherapists, 1 physiotherapist-aide and 2 additional community nurses, costing some £50,000. The NHA approved the request but passed it on to the RHA for consideration on the grounds that RHA monies were a more likely possibility given the severe financial constraints in which the NHA now found itself. The response from the RHA to this request for additional resources, at the time of writing, had not been forthcoming.

The Partnership was charged with the responsibility for identifying gaps in the existing level and mix of professional skills and to assess the specialist staff required to meet demands. The Partnership has the capability, of not only determining what additional staff were required but to appoint the necessary staff subject to the availability of resources.

Work was also progressing on the establishment of a Register of clients and two working groups have been convened to identify and develop plans firstly, for short-term relief for parents and families of mentally handicapped children and secondly, long-term care facilities. An initial report from each of these working groups was presented and discussed by the Partnership at its October 1982 meeting. In general, the two reports were well-received and endorsement for the proposals outlined in each report, was given. It was agreed that the Partnership should be kept fully informed of the

development concerning the two reports and also that back-up support by the Partnership would be required for the schemes proposed for short-term relief.

During this time the Partnership published an outline strategy for the development of services for the mentally handicapped which incorporated a range of ideas and proposals put to the Partnership for the expansion of such services. The document discussed four major scenarios initially approved by the Partnership and outlined a posssible investment programme for the next three to five years. In essence, this manifesto was seen as the basis of a joint policy for the development of mental handicap services and the Partnership was seeking the endorsement of both Authorities of its overall strategy.

Shortly after the Partnership produced its manifesto the RHA published a policy document on services for the mentally handicapped; the contents and implications of which were considered by the Partnership. The document was also discussed by the NHA and it was highly critical of the whole focus and ethos of the Regional policy. The Partnership endorsed the views expressed by the NHA but added its own criticism of the policy. The Partnership was unhappy with the Regional strategy on three grounds: firstly, it deplored the lack of emphasis on the prevention of mental handicap; secondly, it believed that the proposal for sub-regional specialisation would mean the aggregating of mental handicap persons in large institutions which ran counter to current thinking; and, thirdly, that the segregation of mentally handicapped people from the main stream of health care provision was not only naive but potentially dangerous.

That the Partnership and NHA felt able to respond so strongly to the RHA's policy for the mentally handicapped demonstrated a maturity of perception that would have been unheard of had the Partnership not been created and given the opportunity to grow and develop. Indeed, it would not be unreasonable to assume that if the Partnership had not been created then the archetypical thinking embodied in the Regional report would have been unequivocally acceptable to all concerned.

Two major issues still remained as potential obstacles. These were the membership and constitution of the Partnership, and that, inspite of the fact that a policy document on services for the mentally handicapped has been endorsed, the local authority continued to pursue projects for the mentally handicapped independently of the Partnership. These unresolved issues are largely inter-related since an agreed constitution would presumably dictate the procedure for each authority to follow in referring schemes/projects to the Partnership. Although the Partnership has yet to reach a firm position on these matters it is interesting to note that the minutes of the April (1983) meeting stated -

> "The general principle of the tri-partite nature of the Partnership being reflected at the various levels of its activities was considered to be of fundamental importance to all present."

There is every reason to believe that these sentiments still hold good, and the latest intelligence (March 1985) suggests that the concept is continuing to prosper even though a number of the original aims and objectives are under review.

It is clear that the Partnership has been the 'success story' of the research, although it was not without some problems; notably the lack of an agreed constitution and policy framework. These factors notwithstanding, there still remains a commitment to the Partnership and a desire to see it succeed.

Finally it seems as though the tripartite structure of the Partnership has had a profound effect upon the perceptions of all concerned. For example, the professional members of the Partnership found that their clinical or professional views were being challenged by the lay people. These challenges were not frivolous but well-founded with the result that many of the professionals have had cause to re-consider their views. The exercise has also proved illuminating for the lay representatives as they have come to appreciate more fully the constraints which handicap the ability of the professionals to respond to a given situation. Clearly some of the professionals concerned regard the questions from the 'public' as unwarranted attacks on their professional judgement but others have been quick to see the benefits of such a dialogue. The end result has been that the Partnership has been a beneficial learning experience for the majority of those involved.

It will be apparent from the foregoing analysis that, although each joint planning team had a common origin and overall philosophy, each chose to interpret and carry out its remit in very different ways. This evolvement of a separate planning and policy rationale occurred inspite of the fact that each planning team shared a common core membership, comprised of NHA officers, health professionals, in

particular medical personnel, and representatives from the Social Services Department of the local authority. Why these two planning teams should choose to function so differently is difficult to determine empirically, but a number of hypotheses, with supporting evidence where applicable, can be advanced and each will be discussed in turn. The hypotheses or distinguishing features which enabled one planning team to succeed where the other failed were: a committed leadership; lack of constraining services or facilities; relatively little conflict between planners and the caring professions on the type of service required; and a shared sense of urgency that something had to be done. These features form the core of the discussion in the following Chapters Six - Nine, beginning first with a consideration of the questions of leadership and power in planning and policy-making.

CHAPTER SIX

POWER AND INFLUENCE IN HEALTH PLANNING AND POLICY-MAKING

This chapter marks the beginning of a different and new phase to the thesis where the emphasis shifts from the theoretical and descriptive to the contextual. The previous four chapters were concerned with setting the scene for planning and policy-making in the NHS through an investigation of the process as it was conducted within one health authority. What now follows is a discussion and analysis of how the planning process unfolded as a result of the investigation. The conventional wisdom regarding planning and policy-making as articulated by informed observers is complemented and contrasted by the findings of the research and from interviews conducted with some of the main protagonists involved in the process.

Policy-making and the decisions taken in support of the policies, at least in the health service, could be described as organisational chaos. The procedure is organisational in the sense that there is a known, if not agreed mechanism and structure for determining policy and for the decisions that follow therefrom. It is a chaotic process because almost everyone working in the health service is a decision-maker. Or as Klein has put it, "what makes the NHS unique is precisely the fact that health care is the product of countless individual decisions made every day by men and women with a wide range of professional and occupational skills, each of whom tends to enjoy a large degree of autonomy or discretion in his or her own particular domain of activity" (1984b, p. 1706).

Clearly the degree and scope of individual autonomy will vary according to professional and occupational status with the medical profession ostensibly having the greatest domain of influence. Thus from an organisational perspective it is very difficult to state precisely who is responsible for what - who is the decision-maker. Paradoxically, when everyone is a decision-maker, in essence no one is, because one's ability and scope for making decisions is constrained by everyone else working in the health service. Consequently, "the reality of decision-making in the NHS is different from the constitutional theory on which its organisational charts are based" (Klein, 1984b, p. 1706).

This diverse and pervasive form of decision-making, characteristic of the NHS, distinguishes it from nearly every other type of organisation be it public and/or private. Therefore, as Klein has noted, decision-making in the NHS does not lend itself to examination through conventional means, nevertheless there are aspects of organisation and management theory which do mirror or parallel that which does occur in the health service. This chapter will discuss some of these common aspects beginning with leadership and then going on to consider questions of power and influence drawing on the similarities and identifying the major differences where appropriate between the NHS and conventional wisdom gleaned from elsewhere. The discussion will be buttressed with specific examples drawn from the research domain to either substantiate or refute the application of standard organisational theory to a NHS setting.

Leadership

Leadership, like management is an elusive concept; one intuitively knows what it is, yet one has difficulty in formulating a precise definition. Longest, for example, defines leadership as "the accomplishment of organisational objectives as the result of interpersonal relationships between the leader and those he or she leads" (1984, p. 151). This definition, he readily acknowledges is untidy in the sense that it could also be construed as a definition for management itself and yet the two concepts are not the same. Management incorporates planning and organisation whereas leadership is the art (or science) of getting others to follow. Thus a good manager might be a poor leader and a good leader could be a bad manager. The ideal, of course, is that both characteristics should be manifest in the same person be they planner or policy-maker.

Leadership if considered within a management context, can then be defined as the "ability to inspire and influence others to contribute to the attainment of objectives" (Longest, 1984, p. 152). A similar definition of leadership is that give by Liebler, et al who see it as "the influencing of individuals to strive willingly towards the objectives of the group; it is the art of inducing members to accept and accomplish the work necessary to reach the objective" (1984, p. 146). Both these writers perceive leadership as an attribute which is bestowed upon an individual by virtue of ability, and not necessarily derived from that person's position or possession of power. In other words, leadership in this context obtains from a variety of factors, some personal, some not, and not because that individual has some position of power whereby they can force others to

do their bidding. As Leibler, et al note, "leadership is distinguished from power in that force is not a factor in leadership as it is in power relationships" (1984, p. 144). Having said this, of course, it does not mean that power is not a factor in leadership as it clearly is relevant in the hierarchical structure of an organisation where it is of lesser importance is when dealing with groups comprised of individuals of similar rank and status in an organisation, such as in the NHS.

In formal organisations where there is a clear line relationship the functions of the leader are relatively straightforward. He/she is expected to influence, control and persuade the group to work towards/within the overall objectives of the organisation. In less formal settings where there is no clear line of responsiblity or accountability, the role and function of the leader become more difficult to define since a position of leadership could be bestowed upon a person because that individual is recognised as possessing the ability to create the necessary climate of change which is essential to the organisation's continued survival (Bennis, 1973).

Leadership can be expressed or exercised in several different ways and the operative style is primarily derived from the leader's personality and behavioural characteristics. This combination of personality and personal traits gives rise to a 'leadership style' of which the following are illustrative.

Autocratic leadership - this style of leadership is one in which exact and precise details are given to a subordinate of how a particular

task is to be undertaken. There is no room for initiative on the part of the employee or other members of the group. The form of leadership displayed here is one in which there is a high degree of centralisation coupled with a fairly narrow span of management (Liebler, et al 1984). The leader is the decision-maker with no participation in the process by others. In this case power resides with the leader who brooks no challenges to his/her authority - the so-called 'Theory X' of management identified by McGregor (1960). This style of leadership is not common in the NHS although there is no doubt that specific examples could be found if one looked long and hard enough. In the study area, there was no evidence to suggest that this model was applicable to the decision-making behaviour demonstrated by the planning process.

Laissez-faire leadership - this style is in many ways the antithesis of the autocratic school of leadership because the leader operates on the assumption that everyone in the group is capable of self-motivation or leadership. Thus there is no real requirement for a leader only for an adviser or consultant as and when requested. Just as with the autocratic form of leadership there is little or no evidence to suggest that the laissez-faire model is typical of the NHS. It may be that certain groups pursue specific issues or operate in a somewhat autonomous manner (such as doctors and to a lesser extent other professions allied to medicine) but each would acknowledge that they are part of an organisation and as such subscribe to its rules.

Bureaucratic leadership - this is considered to be similar to autocratic leadership because the institution's or organisation's rules and regulations are the driving force behind this style of leadership. Gibb (1971) has used the term 'defensive leadership' to describe similar activities. The bureaucratic model of leadership, indeed as does the autocratic style, inhibits or hinders innovation and experimentation and instead encourages the maintenance of the 'status quo'. Most informed observers of the NHS whilst not commenting on leadership per se in the health services appear to suggest that this modality is very common in that there is a lack of innovative and change-oriented decision-making and that this timidness on the part of those in charge is primarily associated with a desire to live within the rules for fear of annoying or upsetting certain professional groups or members of that group (Ham, 1981; Haywood and Alaszewski, 1980; Parston, 1980). An acknowledgement that there are those who, although outside the standard management structure, nonetheless exert considerable influence in a covert way over the decision-making process (Johnson, 1972; Wilding, 1982). This theme of professional power and influence will be discussed in more detail in Chapter Seven.

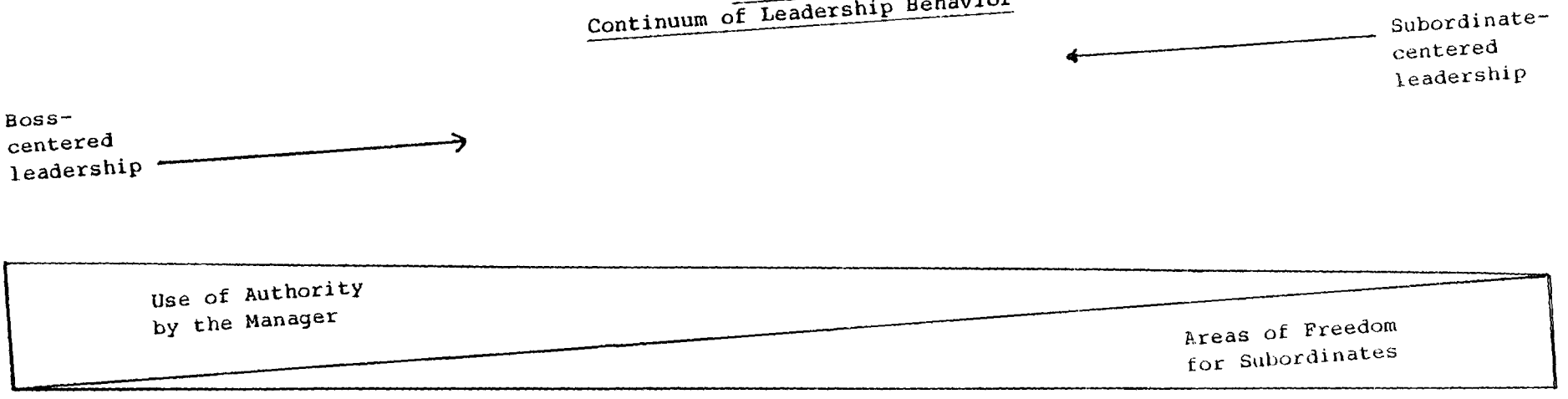
Participative leadership - this method is generally characterised by a strong determination of the leader to totally involve the group in the decision-making process. Consultation is the watch-word of the participative leader as he/she seeks to maximise to the full the range of talent and experience embodied in the group. The leader is the facilitator of this process of group involvement in policy- and decision-making. Consultation does not imply or suggest dilution of

formal authority or responsibility since in most cases it is the manager or leader who retains the right to make the final decision. This style does have certain advantages, not least of which is the high degree of commitment generated for the agreed policy or programme which in turn greatly enhances the likelihood of the implementation of the decision. Participative leadership or 'Theory Y' is predicated on the assumption that people are essentially responsible and self-motivated provided that management creates the necessary environment for such traits to flourish (McGregor, 1960).

The purpose of this chapter is not to create a lengthy treatise on leadership, but rather to suggest that leadership is a crucial element of policy- and decision-making irrespective of whether or not one is dealing with a hierarchically aligned organisation or one such as the NHS, which is a polyglot of different professional groups ostensively sharing a common goal. The styles of leadership discussed above could also have been expressed as a continuum (figure 6.1) which illustrates most forcibly the point that none of these modes of leadership are mutually exclusive that is separate and distinct - as elements of each are generally to be found, to a greater or less degree, in any leader or manager and should be varied to suit the particular demands of the task, situation, and followers.

Such diverse yet interlocking styles of leadership were evident in the study area. Each JPT, although possessed of a common origin and overall philosophy, chose to interpret and exercise their specific remit in very different ways. This application and implementation of separate planning and policy rationales occurred despite the fact that

Figure 6.1
Continuum of Leadership Behavior



Source: Tannenbaum and Schmidt, 1958.

each planning team shared a common core membership, comprised of NHA officers (mainly, but not exclusively from the policy and planning division), health professionals (particularly, medical and nursing personnel), and representatives from the Local Authority's Social Services Department. Why these two particular planning teams should exhibit different behaviour is difficult to determine empirically; however a number of possible 'explanations' can be advanced, with some supporting evidence.

In many of the recent studies of policy-making, planning and decision-making the question of leadership has not been a major topic of investigation, at least not in any explicit sense. For instance, Battye, et al (1980) in their study of the NHS planning system at District level did not consider, inter alia, questions of leadership nor were they particularly concerned about the role of the chairperson of such teams (the de jure if not de facto leader) when assessing the overall effectiveness of the team approach to planning. They did suggest, however, that the administrator, the community physician and the hospital consultant were key personnel or actors in the planning process. It is not unusual to find that one of these individuals is chairperson of the planning team.

Most analysts of policy- and decision-making in the NHS have tended to focus their attention on the various actors in the process and how they exercised the power and influence generally attributed to them through the organisational structure. This is largely true of the work of Barnard, et al (1979), Battye, et al (1980), Ham (1980a), Haywood and Alaszewski (1980) and Hunter (1980) among others.

Leadership, while not a specifc issue considered at length by these observers of the NHS, was at least implicitly acknowleged in their analysis of policy and decision-making and its attribute planning; that the role of the chairperson was crucial to the outcomes identified.

At the recent European Conference on Planning and Management for Health held in The Hague a report Leadership in Planning and Management for Health stated that "if planning is about securing action, leadership is about ability to create constructive ideas on how to launch this action" (WHO, 1984, p. 5) and how to ensure efforts are channelled to achieve the task goals. Such leadership, to be effective, combines the formal and the informal and assumes that roles and tasks will vary according to the actors involved and the particular planning structure in operation. In general, however, leadership in this context, and especially in the health sector "is not so much a question of power as a question of competence and ability to influence through provision of facts" (WHO, 1984, p. 6). With this in mind, attention turns to the question of leadership in the NHS as demonstrated through an assessment of the behaviour exhibited by the chairpersons of the joint planning teams studies - JPTE and JPTMH. As Fiedler (1967) has demonstrated, the chairperson of any group can be considered, de jure, to be the leader of the group. It is clear from the assessment in Chapter Four of how each joint planning team operated that, not only was the role of the chairperson crucial, but so too were the supporting roles played by the NHA planning staff. In an attempt to more fully understand the relationship and role of the chair in the policy-making and planning

process, views were sought from team members as to their assessment of the chairperson's duties and how these were discharged. In effect, what was being asked of them was their appraisal of the chairperson and by inference what should be the attributes necessary for good leadership. In general, the consensus of opinion on the chairperson was that the position was one of crucial importance. As one medical member of the JPTE planning team put it "committees stand or fall by virtue of the ability of the chair", who through the efficacy of his position "can put through or block developments". A nurse member of the same planning team, however, saw things slightly differently and whilst conceding that the chairperson was important, was of the opinion that the style of leadership appertaining owed more to the fact that the chair was a medical person who tended to view matters in medical terms and as a result this was the context in which policy affairs were discussed. The Local Authority member of the team added a different dimension to the traits necessary for good leadership/chairpersonship and this was a "credibility factor"; the ability to react to suggestions and ideas and to get things done.

The JPTE has had, since its inception, two chairpersons, both of whom have been medical personnel - one was community-based, the other hospital-based. Given the importance which Fiedler (1967) attaches to the chair and the opportunity that goes with it to play a major role in determining policy outcomes one would expect the chairpersons of the JPTE to play a more dynamic part in the decision-making and policy formulation process if only because of their considerable influence over determining which items should or should not be included on the agenda.

The behaviour of the two chairpersons of the JPTE in conducting meetings was, in many ways, symbolic of the 'defensive leadership' described by Gibb (1971). This style of leadership is characterised by low trust, data distortion, persuasion bordering on coercion and a high degree of control. Gibb's analogy does not fit exactly the role played by the chairpersons of the JPTE, as there were also elements of the 'bureaucratic" and 'laissez-faire' schools of leadership. The common features from Gibb's model that were in evidence were low trust (restriction of discussion to the local significance of matters of national policy) and high control (manipulation of agenda items) but there was also some evidence that the manner in which discussion occurred was similar to that of 'laissez-faire' leadership in that the discussion was largely unstructured and free-ranging with little or no substance of much relevance emerging. What did emanate from the planning team were planning recommendations generally in line with existing policies and patterns of care. There appeared to be little urgency to the deliberations of the planning team with the leadership displaying some of the more obvious signs of the bureaucratic style by 'playing safe', thus those occupying the chair were more concerned with appearances than with any serious attempt to tackle matter of substance.

It was not surprising, therefore, to find that the JPTE was bypassed by the NHA planners, because in their opinion, the planning team for the elderly was altogether too conventional by seeking solutions to local problems through national policies. In the eyes of the NHA planners this type of planning behaviour only served to reinforce and perpetuate the traditional model of planning because the suggestions

proffered for the amelioration of local problems were generally couched in terms of improvements to existing services. As far as the planners were concerned this was 'bureaucratic planning' at its worse because it tended to perpetuate the medical approach towards preserving what exists, the apparent modus operandi favoured by the JPTE, whereas the NHA planners were committed to a different, more innovative approach to local problems. In other words, the NHA planners were concerned with local issues entirely, felt less constrained in their regard for existing services and therefore were less inhibited in their search for solutions. Indeed, it appeared that the planners relished their somewhat unorthodox approach by challenging the so-called conventional wisdom, as articulated by the JPTE, about what should be the overall pattern of care for the elderly. The reason that the planners did not feel constrained in the same way that the JPTE did could be attributed to the fact that they clearly perceived their task as producing a policy which maximised the potential benefits for the elderly and consequently then appeared to have no qualms about pursuing such a policy. Their motivation for so doing is discussed later on in Chapter Seven when the role of the planner in the planning process is considered in some detail.

The JPTMH, although similar in concept and composition to the JPTE, appeared to enjoy a very different form or style of leadership, at least, in the latter stages of its existence. In its earliest days its leadership was as moribund as that shown by the JPTE but things changed early on in its development that eventually led to the JPTMH taking a very distinctive path. Why these two planning groups should

function so differently is difficult to ascertain precisely but professional background and prior experience would appear to be an important factor. In the case of the JPTMH both of the chairpersons were administrators, the first one from the NHA and the second from the Local Authority's Social Services Department. One reason why these chairpersons were more successful in developing locally based policies than their JPTE counterparts could be attributed to the fact that they were both used to working with committees and therefore were more astute at manipulating events and guiding issues through the joint planning team. An additional and possibly related factor was the personalities of each chairperson - they were both very charismatic individuals, who, when committed to a project, were determined to see it through to implementation which may well have produced a sort of 'band-wagon' effect which influenced the other members of the JPTMH to respond accordingly. Or, as one professional member (psychologist) of the team suggested the team's success could be ascribed to the somewhat unorthodox chairpersonship of the JPTMH whereby existing standards and norms for care and services of this client group were largely jettisoned in favour of a team oriented approach to the problems. This unconventional approach to leadership sounds remarkably similar to McGregor's 'Theory Y' or democratic style of management where everyone has a personal stake in the outcome. Thus the installation of a sense of collective ownership by the planning team in the final product - the policy or plan - is of particular importance and it would appear that such a commitment is very dependent upon the style of leadership adopted.

One conclusion which could be drawn from this assessment of the role

of the chairperson in planning and policy-making is that although the role is a crucial one it is but one ingredient in the recipe of success for planning and policy-making. In Handy's (1976) parlance the leader is both an ambassador - representing his group to people and other groups and by screening out organisational 'noise' so that the workings of the group are expedited - and a model - the embodiment of the organisation which those in the group are striving to emulate. Elements of Handy's paradigm were discernible in the leadership provided to the JPTMH and which were not evident in the JPTE. However, as Barnard et al concluded, "it is not enough to allocate certain roles..... and expect the system and the individual to respond accordingly (since) the resources available to individuals are certainly a significant factor in the way they perform their roles as are structural and political forces" (1979, Vol. 2, p. 83). Nonetheless, leadership, as embodied in the chairperson is important because of:

a) influence over agenda items;

b) an understanding of the political nature of the issues under consideration;

c) the commitment brought to the position; and,

d) the ability to inspire and/or motivate others to work for common goals.

In a monolithic organisation, such characteristics in a leader may be sufficient for managerial success, whereas in a polyarchical organisation such as the NHS there are other forces at work which may determine whether or not a particular policy is acceptable. In the NHS responsibility for decision-making is diffused over several groups

- professions - which have a greater or lesser say in the outcome. The end product of such a process is in many ways dictated by the power and influence which these groups wield, either in conjunction or in competition with the leader.

Power and Influence

Before discussing the various ways in which different groups obtain and apply the power and influence attributed to them it is first necessary to define these two related concepts. Liebler et al defines power as "the ability to obtain compliance by means of coercion, to have one's own will carried out despite resistance' (1984, p. 134). They go on to offer a definition of influence as "the capacity to produce effects on others or to obtain compliance but it differs from power in the manner in which compliance is evolved" (p. 135). Thus there is a subtle but important distinction here and that is; power equates with force (either explicit or implicit) whereas influence facilitates consensus.

Influence is meaningless without power - influence supplements power. Yet Handy suggests that possessing power itself is not as important as the ability to influence since "the power to influence is something that most people would like more of, in some respect, even if they do not want the responsibility that may go with it" (1976, p. 111). Perhaps then the real issue is the power to influence people for as Likert (1961) has revealed, in those groups where the members feel that they each have more influence there appears to be a corresponding increase or improvement in their decision-making capabilities. The possession of power or ability to influence (resource) does not

necessarily lead to the application of influence (process) and therefore it is important to distinguish between them (Handy, 1976). Since influence derives from power it is apposite to consider, albeit briefly, the sources of power. Before doing so, there are some necessary qualifications or considerations that should be borne in mind and these are the relativity, the balance and the domain of power.

The relativity of power - the effectiveness of the power possessed by any one person is a function of the environment or circumstance in which that person is placed and therefore will rise or fall according to the composition of the group and the changes which occur in its membership. In other words, if A's source of power has no meaning for B in a particular situation or circumstance, then A's power is ineffective either because it is not acknowledged or because it is judged to be unimportant (Handy, 1976).

The balance of power - power is not absolute in the sense that A has power and B has none. There is always the opportunity for subversiveness or 'negative power' when someone believes that they are being unduly oppressed by the exercise of power. Therefore, just because A possesses power it does not automatically follow that A can influence B as this is dependent upon the power which B holds (Handy, 1976).

The domain of power - the exercise of power is rather like a game in which individuals are constantly trying to increase their own power while restricting that of their rivals. As Handy states "few sources

of power are universally valid over all constituencies" (1976, p. 113). Also if one's source of power is challenged it may not necessarily mean that the power base is destroyed but only constricted (Handy, 1976).

The foregoing aspects of power condition to a large extent the manner in which the holder is able to exercise power which may be derived from one of several sources. The classification applied here is that used by Handy (1976) which is itself a variation on that proposed by French and Raven (1959). The sources of individual power are:

1) physical power - the power of superior force;
2) resource or reward power - resources, either material or non-material are possessed and which are desired by others;
3) position power - legitimate power (authority) derived from one's role or position in an organisation;
4) expert power - the power that is ascribed to a person because of his/her particular expertise;
5) personal power - this form of power derives directly from an individual's charisma or personality; and
6) negative power - the capacity to prevent or hinder things from happening or to distort the eventual outcome.

It is from these various power sources that one is able to exert influence of some kind over others.

The classification of power discussed by Handy and briefly outlined above has been done for the sake of convenience, one should be under no illusions that power is exercised in such precise ways. According to Bachrach and Baratz, power is never applied in a straightforward

manner, it is somewhat two-faced in its application.

> "Power is exercised when A participates in the making of decisions that affect B. But power is also exercised when A devotes his energies to creating or reinforcing social and political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A. To the extent that A succeeds in doing this, B is prevented, for all practical purposes, from bringing to the fore any issues that might in their resolution be seriously detrimental to A's set of preferences" (quoted in Parston, 1980, p. 39).

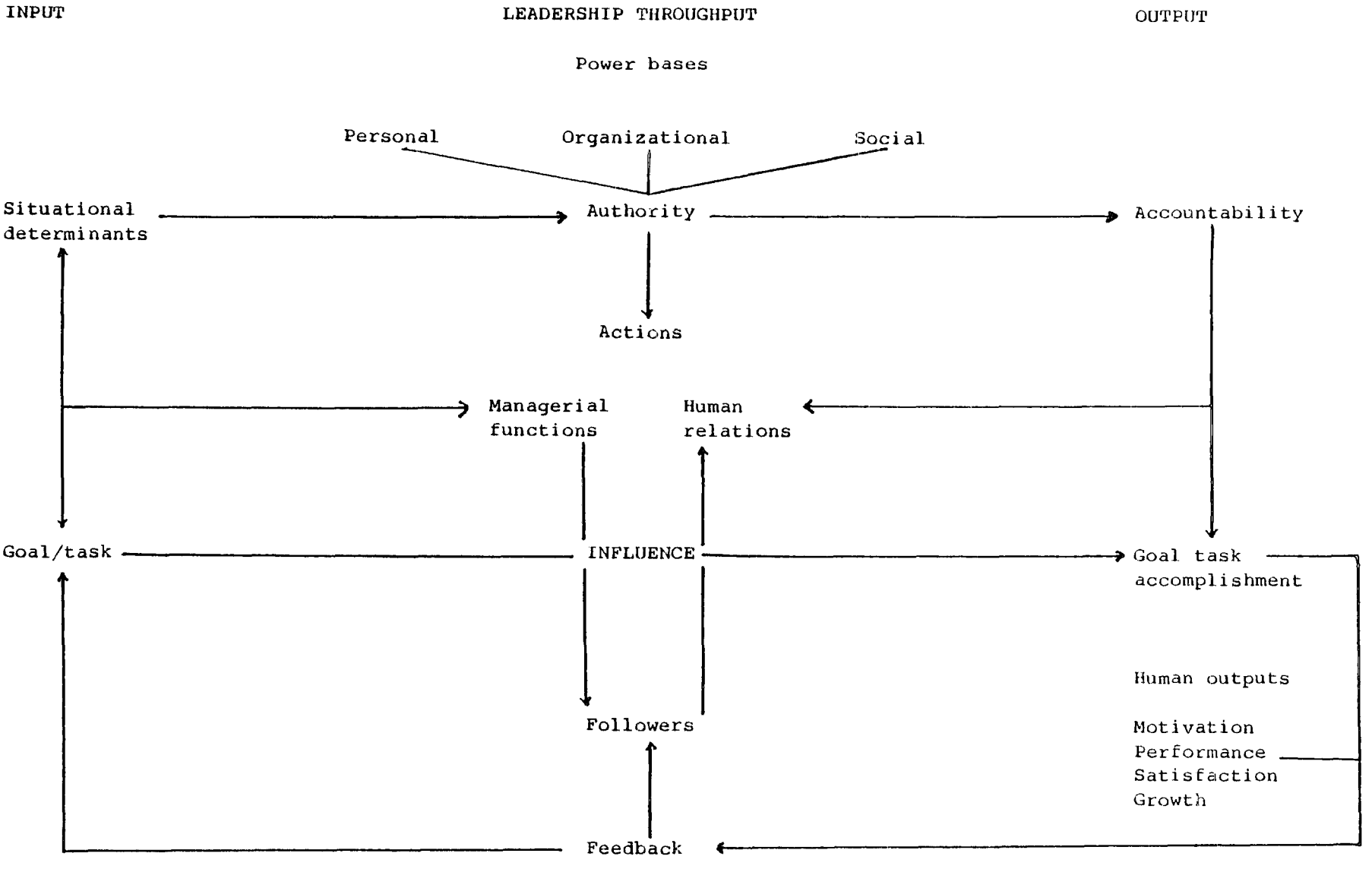
Bachrach and Baratz (1970) have termed this process of conflict minimization 'non-decision making' because contentious matters are never allowed onto the agenda. In many ways the activities of the JPTE accord with this model since local issues were excluded from the agenda and were replaced by matters deriving from national policies. Thus the local and by definition contentious issues were substituted by the non-threatening national policies. Group cohesiveness and solidarity was considered to be more important than any serious and potential disruptive debate over local problems.

The activity described herein is very close to Luke's third dimensional view of power which he defines as the "contradiciton between the interests of those exercising power and the <u>real interests</u> of those they exclude ... who may not express or even be conscious of their interests" (1974, p. 25). How this situation developed is

difficult to describe clearly and concisely but has in part been explained by the various sources of power available to the leadership (planning team chairperson) and how that power was exercised. This does rather leave open the question as to why the JPTMH should function so differently even allowing for the distinctive leadership styles displayed. It does seem clear, however, that it cannot be attributed to power and influence alone. What seemed to have taken place might best be described as 'synergism' - the term used by Claus and Bailey (1977) to refer to the power of co-creation and collaboration whereby the skills and expertise (power) of others is considered to be an essential and necessary ingredient of successful policy-making. Their PAIL (Power/Authority/ Influence/ Leadership) model (figure 6.2) would seem to epitomise the sort of conditions and factors which underpinned the working patterns of the JPTMH and its reincarnated self - the Partnership. It would appear, therefore, that there was some sort of collective understanding or sharing of power sources to enable one planning team to achieve the progress it did while the other planning team, sharing a similar core membership, was essentially moribund.

Power and influence alone cannot be the only explanation for such different behaviour between planning teams; so other factors must have been operating here. As Bachrach and Baratz have noted "power is neither the only nor even the major factor underlying the process of decison-making" (1970, p. 39). To pursue this line of reasoning further would require a major shift away from the domain of power and into the realm of politics, and that is the subject of the next chapter. However before leaving this discussion it is important to

Figure 6.2
Leadership Throughput - The Power/Authority/Influence/Leadership Model



Source: Claus and Bailey, 1977.

establish the context within which the wider issue of politics is to be considered and also to show that the political domain is a natural extension of the debate about power, influence and leadership.

At the beginning of this chapter reference was made to the diffused nature of decision-making in the NHS. This diffused decision-making, according to Klein (1984) is a consequence of several factors or elements all of which exhibit a constraining influence on the outcomes of the process. These inhibitors are in the main: 1) history - past decisions invariably influence future ones because of the impact these have (or had) on the available resources and, 2) clinical autonomy - hospital doctors are quite free to decide who should receive treatment and what sort or type of treatment they should obtain which means that the health authority cannot make decisions regarding delivery of services. Thus there is a very clear "mismatch between the distributions of nominal authority and effective power" (Klein, 1984, p. 1706). The impact and the effect that this has had on policy formulation, planning and decision-making in the NHS has been quite well documented (Ham, 1981a; Haywood and Alaszewski, 1980).

A central feature of the NHS is the clinical autonomy enjoyed by the medical profession, which ensures that the best clinical conditions are made to practise medicine. A related issue is the general power and influence enjoyed by other health professionals over matters of policy with the doctors pre-eminent among them. As Illich notes, "they determine <u>what</u> shall be done and for <u>whom</u>" (1978, p. 342). Together these factors can be seen as imposing a formidable barrier to

change - a barrier which inhibits innovation and/or experimentation and encourages planning which amounts to little more than a repackaging of existing services.

Alford (1975) in his seminal study of the politics of health care in New York City argued strongly that there are certain and particular 'structural interests' in health care which prevaricate against measures and attempts at reform. These structural interests are considered to be more than just interest groups seeking the appropriate opportunity or circumstance to present their particular care, rather "structural interests either do not have to be organised in order to have their interests served or cannot be organised without great difficulty" (Alford, 1975, p. 14). These structural interests have been classified as, dominant, challenging, and repressed. The dominant group are also referred to as 'professional monopolists' and are generally regarded as being in the main, medical, but other professional groups are also included. According to Alford, the professional monopolists .... "are satisfied with the status quo and do not form part of the ... reformers .... except when their powers and prerogative are threatened by others" (1975, p. 195).

The second group, the challengers or 'corporate rationalists' are those in management and administration charged with the responsibility of planning and managing the health network. They see that their ability to discharge their responsibilites effectively and efficiently is in many ways hindered by the power and influence and independence enjoyed by the professional monopolists and therefore actively seek ways to minimise their impact. The third group, the repressed, are

in Alford's term, the rest, those groups such as consumers, patients, patient advocates (Community Health Councils) and the like who are important elements in the health care network but who are little more than pawns in the health care chess game being played between the dominant and challenging forces.

It is the conflict between the dominant and challenging groups which is political because, although they pursue different claims, they do share a common concern and that is to exclude or at least to hold at bay the claims of the repressed interests for a say in the debate. The political environment in which these protagonists operate and the manner in which they conduct themselves are not easy to define in precise terminology because of the rather complicated and entangled web each weaves in its attempt to outwit or put one over on the other. One way of trying to get an insight into this complicated and convoluted process was to start with a consideration of the philosophy and rationality which underpins the stance of each group. This is taken up in the following chapter which looks at different philosophies of care, the concept of need and demand in health, and how these are translated into a package of services.

CHAPTER SEVEN

POLITICS OF POLICY-MAKING AND PLANNING

The discussion, so far, has been content to consider planning as a process - through an examination of the procedures involved and their impact upon policy-making. It was noted that the planning undertaken in the study area displayed distinctive features and these distinctions persisted despite the fact that there existed a common, formal mechanism for governing the planning process. There are several factors which seem to influence planning and policy-making in health care and the foregoing chapter has considered the importance of leadership and its companions, power and influence in decision-making.

Inherent in the discussion has been an implicit notion of health and health care and it has been assummed that this notion is one which is generally shared. It would seem prudent at this stage to consider this notion of health, in order to place in context the assumptions (acceptable or otherwise) which underpin the proceeding discussions and which also buttress the hypothesis advanced herein.

The ultimate goal of any health care system is often considered to be health - an illusive and undefined concept which is generally accepted as necessary and important. The problem of health is that it is both an ideal and a norm (Miles, 1978). As an ideal it can be defined in very general terms as in the WHO slogan 'Health for All by the Year 2000'. As a normative concept, its definition is much more problematical since health is in the eye of the beholder. Society

places considerable store on health, or at least the image of health, and such definitions of health care made in the social context. For example, in much of Western Society, good health is often associated with the 'body beautiful' - to be slim means to be healthy, whereas, in other societies, the converse is taken as a sign of health.

This background of conflicting values and definitions of health provides the setting in which planners, providers, and policy-makers consider the package of health care services to be made available for a given population or area. The political argument centres on who should provide the services, who should determine what resources are to be made available, and what should be the criteria on which health plans and policies are to be decided. Such questions, as Topliss (1978) suggests, can only be understood and considered in the light of four main themes: social significance of the state of health; the individual and health care; institutions and communities; and the medicalization of society.

The first - social significance of the state of health - refers to the different perceptions of health and illness which are manifest within society. Compare, for example, the tolerance given to the so-called minor ailments such as colds and 'flu, with the pressure placed on individuals and parents to ensure that they and their children are protected via immunisation against certain diseases. Differences such as this, whilst difficult to explain, nonetheless do seem to contribute to the 'politics of health' in that concern over specific illnesses leads to particular legislation to control and/or regulate access to health care. The totality of health care made available

stems to a large extent from the value placed on particular aspects of health by society.

The second factor - the individual and health care - is in many ways an extension and refinement of the first theme, in the sense that an individual's perception of health is a consequence of the values or beliefs held. Generally speaking, it is the individual who decides when he/she is ill and also how much he/she is prepared to sacrifice for good health, or for an acceptable state of health and/or to avoid ill-health. It is this personal judgement which also governs the extent to which a person will accept and follow professional advice. Probably the best example of this behaviour is attitude to smoking; there is considerable medical evidence to suggest that there is a strong association between smoking and coronary heart disease and yet, in spite of considerable publicity about the hazards, people still smoke though many accept that to continue to do so may well be harmful.

The third condition - institution and community - highlights the separateness of the two entities. To go into hospital, for whatever reason, is often regarded as a form of removal from society. Hospitalization has a certain negative connotation within society, possible failure or some sort of inadequacy suggestive of individual failure or weakness. The separateness of institution and community is evident in the fragmentation of services offered by provider agencies. The joint planning practice in NHA clearly supports this contention since both providers of services, the health and the local authority tended to take a sectarian view of problems in that in

considering services for the elderly, for example, the issue tended to revolve around the question of whether the number of hospital beds available was consistent with regional and national norms. By taking positions, which in many ways polarised the joint planning process, both authorities became drawn into a political debate over who should be considered to be responsible, with each attempting to blame the other for the apparent problem.

The fourth proviso - medicalization of society - underlines the growing gap between the medical model of health and the inability of such a process to make much of an impact on many of the major illnesses evident in contemporary western society; the so-called 'diseases of lifestyle' such as cancer, coronary heart disease, and hypertension. As medical care becomes more specialised, people's expectations rise accordingly because they are often led to believe that more resources for this or for that will have a direct and profound benefit on health. Heart transplantation is one form of specialisation which may foster the belief in people that they need not pay attention to diet, smoking and/or alcohol consumption because if problems develop they can be 'cured' with a transplant. The issue of the 'medical model' versus the 'social model' of health will be returned to later on in this chapter.

Health Field Concept

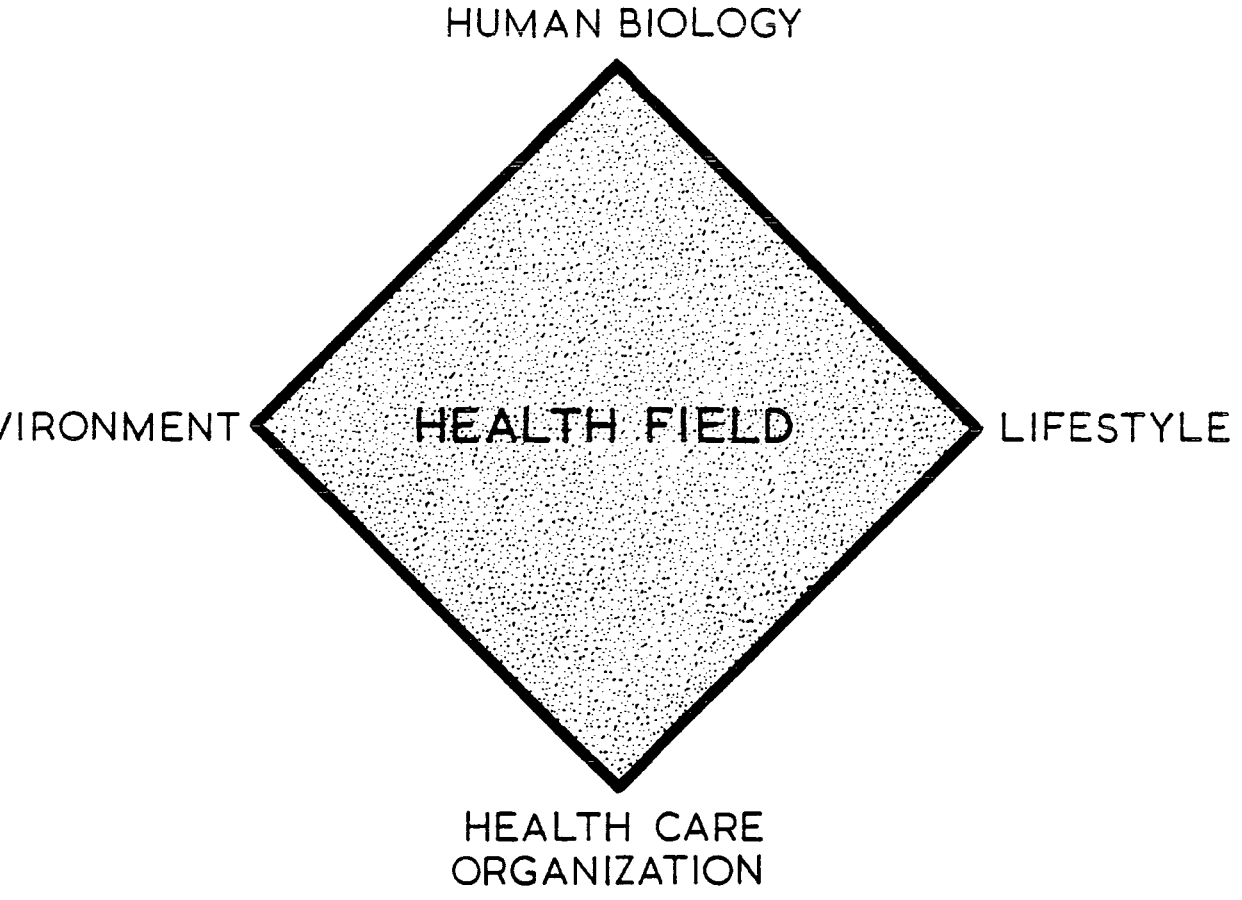
Trying to reconcile these four inter-connected issues places planners, providers and policy-makers in a dilemma in that there is no accepted or recognised procedure for dealing with such matters. This is because tradition has it that all improvements in health care have

grown out of advances in the art and/or science of medicine. Such a rosy picture fades somewhat when one considers that many of the so-called advances in health came about through changes in diet, the physical environment and habits of procreation. The fact that medicine alone was not responsible for the significant changes which have occurred in health, does suggest that planners and policy-makers must broaden their field of enquiry to include other related factors such as lifestyle, environment and the health care organisation itself.

The linking of these three key elements with a fourth (human biology) has been called the 'health field concept' - a term first promulgated in 1974 when the (then) Federal Minister of Health for Canada, M. Lalonde published A New Perspective on the Health of Canadians (1974). In essence, the document argued that health policy matters were most generally but wrongly seen as problems for and with the health care system or organisation and not of consequence to the other three constituents (figure 7.1).

The rationale for this approach to health care development was that policies rooted only in medical care or those aspects of it acceptable to the health care structure tended only to perpetuate existing patterns of care and consequently had little effect or influence on the general level of health in a population. This is a point which Parston emphatically makes when he states that "nowhere is planning conducted on all fronts of the health field irrespective of the political and economic administration of health services" (1980, p. 86).

Figure 7.1. THE HEALTH FIELD CONCEPT



Source : After LALONDE, 1979

It was hoped that the 'health field concept' would overcome this rather narrow approach to planning and policy-making through the twin aims of 1) providing a better understanding of the factors which contribute to health and disease; and 2) facilitating the identification of the various courses of action which might be taken to improve health. This model of planning in many ways epitomises the ideal which everyone aspires to but actual practice suggests sights are considerably lower with service provision largely determined by concepts of need and demand. The reasons why 'the health field concept' has not been uniformly endorsed by planners and policy-makers alike are that firstly, it is complex and the inter-relations between the four elements are not always clearly understood. Secondly, the model accepts that medical care is fallible, a condition which is decidedly unpalatable to certain elements who argue that there are little or no grounds for such a view. And thirdly, the cornerstone of the model rests on radical behaviour changes not only for the consumer or user of health care but also for the provider; changes which unfortunately have not been generally forthcoming.

Planning for 'Need'

The cornerstone of health care delivery and the planning of services was the 'needs' of the various groups making up the population. This concept of 'need' is difficult to define and measure since individual requirements for health care are often different from those of a particular group. For example, in dentistry the service response to the patient's needs seems relatively straightforward; prevention, fillings, and removal and/or replacement of teeth. Whereas the needs

of the elderly may encompass a wide range of different services, both health and local authority provided, in order to provide a complete programme of care. What is patently clear is that the concept of 'need' whilst most difficult to define and measure, nevertheless requires discussion since it forms the foundation upon which health care services are to be provided. It is important, therefore, that the concept of need and its application to the planning of the health services be understood. Kalino (1979) has defined 'need' as the difference between observed and ideal levels of health. In other words, he is suggesting that the 'total needs' of a population can be determined through an understanding of the current demand for health services in combination with the perceived need. Unfortunately, he does not elaborate on how this perceived need might be determined or by whom. Bradshaw (1977), on the other hand, has argued that there are four definitions of need which are used by administrators and providers. These are:

Normative need - a 'desirable' standard or level of care is set and is then compared with the existing standard or level of care. Any ensuing shortfall implies that an individual or group is in need. Relying on pre-determined standards does not necessarily mean that a need exists in an absolute sense, since it may not correspond with a need established through alternative means. Also different providers may well have different views on the desirable or appropriate standard or level of care. In the end, it is a value judgement by the so-called experts on whether or not resources should be devoted to meeting the need and whether or not the necessary skills are available to solve the problem

that determines the standard or desired level adopted.

Felt need - determined by asking the people what they want and as such fails to measure 'real need' because the responses obtained by this procedure are limited by the individual's perception of the problem. For instance, some people may not know if a service is available, and consequently will not regard themselves as being in need. If they do know, they may not know how to use it properly, and may consider themselves in need, when in fact they are not.

Expressed (or unmet) need - this view of need equates with the demand for a service. In other words, a population is considered to be in need when the demand for a particular service exceeds the current available supply. A good example of expressed need is hospital waiting lists because, in general terms, they imply that there are more people needing a service than the current resources are capable of supplying. Some pundits have argued though that waiting lists are symptomatic of popular demands for a particular service, and therefore, not indicative of need per se.

Comparative need - is determined by studying the characteristics of a population or particular sub-group of that population who are in receipt of a service. Those with similar characteristics but not receiving the service are considered to be in need. Caution is just as important here, as with the preceding descriptions of need, because any absence of a service according

to a comparative study does not necessarily indicate that the area or its population without the service is in need of that service.

The rationale for highlighting those four concepts of need is not to give undue weight to the measurement problems associated with each concept, but rather to re-iterate Bradshaw's point that together these four definitions of need approximate 'real need' and that collectively they do go some way towards measuring 'real need'. Indeed, this position is endorsed by MacStravic (1978) who argues that a reasonable picture of need can be determined through a combination of four measurement techniques; population survey - asking people what they want; demographic characteristics - what features set certain groups apart from others and why; utilisation analysis - how a population or particular sub-group uses the health services; and consensus-reaching - planners, providers and consumers discussing, collectively, the implication of these findings and what they mean to the devlopment of health services.

However desirable these approaches to determining needs may be there is real difficulty both conceptually - stemming from the various different perceptions of need - and practically - particulary a lack of appropriate data - to developing a realistic measurement of need. In the end, one is left with a combination of demand factors, value judgements and professional interpretations among others as the basis on which need is most often determined. It is important to realise that this imperfect formula for determining need is widely employed

and it is this formula which, more than anything else, has largely determined the current structure of the health services.

Furthermore, this process has become self-perpetuating since the present structure or pattern of service provision has largely determined the parameters on which the requirements for future provision are judged. The reason for such a state of affairs lies with the obvious difficulty associated with the development of appropriate and quantifiable measures of need thus dictating that an acceptable surrogate or alternative method was needed. The surrogate so employed has been to use demand as an indicator of need; a demand which stems in the main from the existing configuration of services and the use made of them.

The consensus that demand is an apparent acceptable alternative to need raises important questions such as 'what is need' - an attempt has already been made to address but not necessarily answer this question - and 'who determines need'? This latter subject presents one of the greatest challenges to health care providers, managers and consumers because, although they each would acknowledge that the other has a role to play, each party seeks to maximise its own contribution to the procedure for determining need and the configuration of services which follow therefrom.

The political aspects of this process are clearly apparent from Alford's study of health care in New York in which he noted "that there is a reasonably high correlation between ideologies and personal incentives of doctors, researchers, administrators, and the

organisational interests of the medical profession, hospitals or public health associations. That is, there is a high probability that elites will take a public position consistent with the interests of their organisation" (1975, p. 21). This theme will be discussed in detail in Chapter Eight, but mention of it here serves as a poignant reminder that professional judgement and values are formed within a political framework that is not altogether made explicit to others also involved in the negotiations over service related needs and demands.

The environment in which these groups (professional, managers, and consumers) operate largely determines their respective stances as far as equating service provision with need is concerned. Although the environment referred to here can be sub-divided into several components, in reality only two divisions are of interest: the macro-level and the micro-level (Pettigrew, 1985). The macro-level refers to the national environment and the policies and/or guidance which emanate from this source; namely the policies determined either by parliament through changes in legislation or those initiated by the DHSS. Both policy sources can produce fundamental change in the NHS or paradoxically, little or no alteration. This is because some of the policies are compulsory in the sense that health authorities are required to implement them, whereas others are advisory with no sanctions applicable should any particular health authority decide not to effect the policy. The role of the professions or rather their corporate associations is also crucial at this stage since the collective views of a particular association will obviously condition how that profession will respond, either to a specific national policy

or to changes in professional workload such as that which may arise from innovations in medical technology.

The micro-level relates to the local environment within which a health authority operates and is used to describe the sorts of activites which occur therein. Here the interplay between providers or professionals, managers and administrators, and consumers is acted out with the main action occurring between the first two groups. At this level, local facilities and resources very much influence the policies adopted and implemented. The problem is further exacerbated because the protagonists are clearly employing different criteria derived from different models of care in assessing need and demand for health care. The two models enlisted are the 'medical' versus the 'social' pattern of health care.

The medical model dictates that doctors occupy a central role in the provision of health care and that within such provision the hospital plays a major role. The model is predicated on the assumption that ill-health is a consequence of some sort of malfunctioning within the body and as such can be dealt with by specific measures. Illsley (1980) suggests that the medical profession tend to see illness in one of two ways: firstly, as a disease rising from pathological processes; and secondly, as an engineering problem requiring technical repairs. The outcomes of such thinking suggests Ham is that "the medical model emphasises specific, individual courses of illness and searches for specific individual cures for these illnesses" (1982, p. 157). It is this approach which has led McKeown (1976) to the view that because the body is regarded as little more

than a machine, this breeds an indifference to external influences and personal behaviour and it is these two factors which are the real determinants of health.

The social model of health care is that which links ill-health to the external environment and personal behaviour. The major conceptual difference between the medical model as described above and the social model is that it is misleading to view illness as a biological malfunction which can be easily repaired by technical means. Proponents of the social model, such as McKeown (1976) and Lalonde (1974) argue that the body is not a machine and cannot be treated in the same way one might deal with an automobile which needs repairs. The body is a complex system over which the individual has some control but not absolute control. What this means is that attempts to remedy illnesses through medical or medical related interventions alone has not proved to be all that successful. The Black Report (DHSS, 1980b) on inequalities in health stands as a damning testimonial to the inadequacy of the medical model. It is not surprising that many planners and policy-makers sought to undermine the dominance of the medical model by arguing that one cannot look at health services in isolation and therefore attempts have been made to link the planning of health services to the wider environments in which health care issues are rooted.

Politics of Provision

Lee and Mills (1982) identified one of the problems of joint planning to be that it was specifically concerned with strategic or long-range planning, and consequently the issues under discussion seemed to lack a sense of urgency. Furthermore, because most local authorities'

social services departments did not operate a forward planning system their interests resided primarily with operational issues - that is, with issues deserving of immediate attention. To a certain extent this scenario was consistent with the position adopted by the JPTE but these features did not appear to be present in the workings of the JPTMH.

One explanation for this difference was that the health authority provided a service for its elderly population but none for the mentally handicapped. Arguably, existing or established services restrict any planning team's degree of manoeuvrability. For example, both the health authority and the local authority provide services for the elderly but these services are primarily based upon different philosophies of care. The health authority's services are essentially rooted in the 'medical' model of treatment and care whereas the services provided by the local authority may be generalised as a 'social' mode of support and containment - an alternative for those elderly who find living alone difficult. There is a danger in polarising the strategies in this way, but they do, ultimately, determine and condition the approach each authority will adopt to the problems at hand. It is argued that these different viewpoints were partly instrumental in the JPTE choosing to discuss policy issues emanating from the DHSS rather than to grapple with the thorny issues of determining local policies for the elderly. As Barnard et al observed, there is a tendency to concentrate on issues which "do not immediately threaten to disrupt people's established patterns of behaviour" (1979, Volume Four, page 30) [emphasis in original]. The outcome of this reluctance on the part of the JPTE to

grapple cogently with local issues was that their potential for influence was usurped by the health authority's planners who took upon themselves the task of producing a plan for services for the elderly.

In contrast, there was no service provision for the mentally handicapped within the health authority. Thus the planning team was not unduly constrained in its debate on the problems of the mentally handicapped and possible solutions, by any predetermined service infrastructure. In other words, the absence of services and facilities meant that any in-built inertia or resistance to change was unlikely to be an inhibiting factor as far as the planning of future services was concerned.

Resistance to change within the health service is not an inconsequential matter for as Stocking has acknowledged; "In the Health Service for example staff may not be convinced that change is necessary; they may have invested a great deal of time and energy in the established order and change is then an implied criticism of all they have worked for; change may mean much uncertainty and may even be against the personal interest (such as status, work patterns, etc) of those affected." (1985, p. 22-23). This is a theme which Parston (1980) most certainly implicitly endorses in his assessment of why the health care system in Britain evolved in the manner in which it did. Parston's explanation for the particular pattern of health care services which resulted was; "Buildings are easy to envisage, imply

readily identifiable roles in a health care system, and, consequently, are quite easily managed by both planning and funding decision-makers." (1980, p. 91)

It is quite clear that while professional diversification and stratification, and existing patterns of care do not prevent innovation from occurring (Stocking, 1985), they do, nonetheless, present very formidable barriers to change. This state of affairs was quite evident from individual discussions held with a selection of some of the protagonists involved in the planning and policy-making processes in the study area. The views proffered by those interviewed, especially in relation to the question of whether or not an existing panoply of services acted as a barrier to change tended to reflect professional lines: that is, while the planners, nurses, and others were highly critical of the dominating influence of the so-called 'medical model' in dictating the balance of care provided, the medical profession, not unnaturally say the lack of progress is a consequence of inadequate resources, and unnecessary and needless bureaucratic interference.

Organisations do change and new products are developed and research has showed that such change usually occurs because of the efforts of one committed person who champions or pushes the innovation through the organisation. The term used to describe this sort of person is 'product champion' (Stocking, 1985). One of the 'product champions', a health authority planner largely responsible for creation and implementation of the Partnership was rather scathing about the medical input into the planning process. His interpretation of the

lack of progress of the JPTE in policy formulation was due to the fact that ideas generated "did not fit with the views of the medics" who saw proposals for change or suggestions for alternative approaches towards providing care for the elderly as "an attack on (their) professional status". Furthermore this person was rather dismissive of the ability of the medical profession to contribute positively to the planning process because of their tendency to think in terms of "beds only", which "tends to inhibit innovation."

This planner reckoned that the success of the Partnership and its innovative offshoot, the community mental handicap team (CMHT) was, in part, attributable to the fact that there was no medical input. The reason for this, it was suggested, was that doctors were not really interested in mental handicap because its derivations did not fit very easily the medical model of health; that is there was (is) no cure. This lack of interest in the problem rebounded on the medical profession who consequently found themselves confronted with a policy decision not of their making and a service profile in the CMHT which excluded them. The result of this coup, according to the NHA planner, was that some members of the medical profession tried to undermine the policy by challenging not only the grounds on which the CMHT had been created but also its composition ostensibly because they disagreed with what they regarded as the apparent minor role of medicine in the overall programme. It did not appear as if this challenge had been successful although there was a promise of talks on the future medical contribution to the team.

The nurse member of the JPTE attributed the so-called 'poor showing' of the team to the fact that the major concern lay with existing "beds and provision and the location of the beds", thus emphasising the dominance of the medical model in determining health plans and policies. One explanation offered in support of this view was that the chairperson was a doctor who tended to see service issues in terms of medical care and because the planning support from the health authority was relatively low key; this reinforced by default the emphasis on a medical (hospital-based) solution only to the problems confronting the JPTE. This approach to the major issues was regretted by the nurse who believed that some consideration should have been given to the role played by those who worked in the community.

Some of the medical personnel involved in the planning process, perhaps not surprisingly, did not share the view of their nursing and administrative colleagues that the main culprit to building successful plans and programmes was the dominance of the medical model. In their opinion lack of progress lay not in the so-called myopic nature of the medical model but rather in the slow-down/cessation of development monies. There was an acknowledgement from some of the doctors that they were in many ways pre-occupied with running a service, and one which they considered to be quite successful in the past but was now facing certain pressures which had largely arisen because of financial restrictions on new investment. In this respect there was a degree of concordance with the widely held view that the existing configuration of services does have an influence on the future development of proposals and plans. Where the two camps

differ is over the degree of influence with the medics seeing it as the problem of resource constraints and the planners holding to the view that medical narcissism is the real barrier to successful planning and policy-making.

The outcome of this assessment of how different philosophies of care as manifest in the 'medical' and 'social' models of health care, in conjunction with different interpretations over the concept and definition of need, has inevitably led to the painting of a seemingly confused picture of planning and policy-making in a particular health authority. Confusing though this picture may be it is still not wholly complete for, although reference has been made to a plethora of actors in the planning process, little attention has been given to specific roles, other than in passing. Nonetheless, it is evident from the foregoing that certain individuals, especially those who adopt the role of 'product champion', can and do influence the policy-making process. The next chapter explores in considerable detail not only the role that these actors play on the planning stage but also will consider the rationale which underpins their respective stances.

CHAPTER EIGHT

PLANNERS, PROFESSIONS AND THE PLANNING PROCESS

The role played by the various actors in the planning process also influences the degree of success achieved in formulating plans and subsequently, in implementing the plans and policies produced. There are many groups involved in planning, some of whom are more influential than others; an important distinguishing feature of the two planning teams in the research study which despite a common core membership, chose to follow very different paths. Thus, in order to better appreciate the delicate relationship between planning and policy-making in the NHS, it is crucial that the machinations of the various actors involved in the planning process, the particular role adopted by the designated planners, and the environment or arena in which planning operates, are well understood.

This chapter considers, in turn, the interface between the various actors, the planners' role, and the planning environment from a general or theoretical standpoint and also with particular relevance to the study area. It should be borne in mind, however, that it is somewhat artificial to look at each of these concepts separately since, in reality, they are closely intertwined.

Actors in the Planning Process

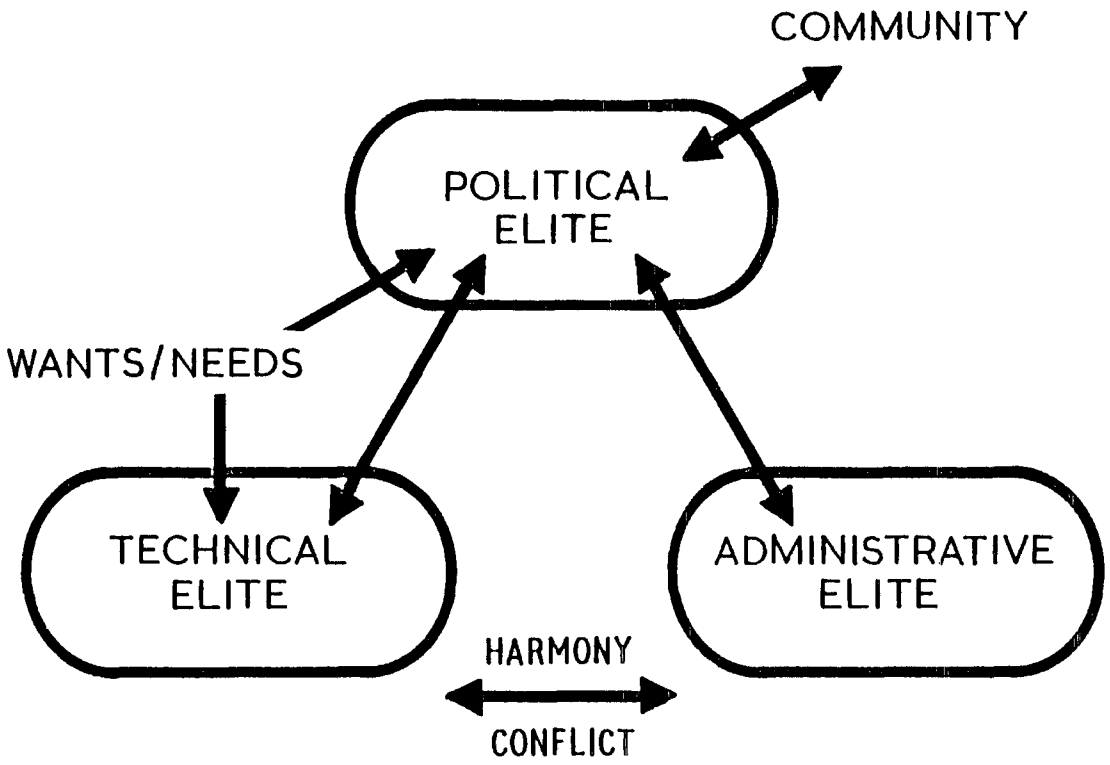
There are many individuals, possessing different skills and expertise from very dissimilar backgrounds, contributing to the planning process. Precisely because there is such a plethora of actors involved in the planning process, a number of significant issues arise

which require explanation or, at least, discussion. A central question is the one of power and influence, be it between the centre (state) and the periphery (local health authority), or between the various professions within the health service. Although Chapter Six discussed the concepts of power and influence in some detail, the inter-relationships between the professions was only briefly touched upon and consequently this theme is continued in this chapter.

Another theme addressed earlier (Chapter Seven) but left incomplete was that concerning the environment, be it social, political or cultural, within which the planning process operates. It was clear from the earlier discussion that the values, perceptions and judgements of those involved are of particular importance and, when allied to a specific power base, can have a disproportionate impact upon the outcome. A starting point for this journey is the consideration of the impact upon planning and policy-making of three distinct yet related groups or elites: political, technical and administrative. The relationship between these three protagonists is shown in figure 8.1. The use of the term 'elite' to describe the different conditions of participants or actors in planning is not new as it accords very closely with the work of Haywood and Alaszewski (1980) who argue that local decision-making in the NHS is essentially elitist in nature.

Political elite - the decision-making body which is concerned with making choices. Such choices are influenced by pressure from the community, advice received from the administrative and technical elites, and the membership's perception and understanding of what sort

Figure 8.1. ACTORS IN THE PLANNING PROCESS



of health care service or system is required. The question of community pressure on decision-makers will be addressed in more detail in Chapter Nine, and therefore, a short illustration will suffice here.

In 1980 the community health councils for Newcastle and Northumberland took advantage of a ministerial visit to the health authority by the then Minister of State for Health, to present an open letter to the Minister decrying the lack of facilities for the mentally handicapped in Newcastle. The purpose of the Minister's visit to Newcastle was to discuss the outcome of a large development to one of the hospitals in the city, and a consequence of his receiving the open letter was to preface his approval of the development with the condition that a development plan for the mentally handicapped must be produced by the end of March 1981.

The joint intervention by the CHCs probably had little effect in the sense that there is no doubt that a plan would have been produced eventually (Petfield, 1983); what they did achieve was to sharpen the sense of urgency about the problem (via the Minister) such that a development plan emerged much earlier than it might otherwise have.

The ability of this elite to effect choice is largely constrained by the role adopted by both the administrative and technical elites, and by the diffuse nature of the membership of the decision-making body. This body is essentially composed of lay members, buttressed by a handful of professionals (usually but not exclusively doctors) who are appointed essentially for their understanding of or interest in health

care. Thus "the criteria for nomination and selection was suitability for the job and not representative skills." (Haywood and Alaszewski, 1980, p. 87). The particular role of health authority members (political elite) was to act as a detached counterweight to the many opinions and perspectives likely to emanate from within the service and to monitor the effects of current policies and any policy changes.

In general, the impact of members in the decision-making process was mainly ineffectual (Royal Commission on the NHS, 1979). One reason, according to Brown (1979), was that there was considerable overlap between members' responsibilities and the duties of their officers whilst lacking constituency and watchdog roles. Haywood and Alaszewski suggest that member ineffectiveness was not one of role weakness but because of the "absence of disagreements and alternative options" (1980, p. 90). In essence the lack of clout by the political elite cannot be laid at the door marked 'technical deficiencies' but rather it is attributable more to the game of 'power politics'. The following passage puts the case most succinctly.

> "Some members felt that officers had too much power, which could be curbed if members knew what they were doing. Inspite of the general philosophy of openness, too, some officers were reluctant to risk interference by offering information too freely. Like many technocrats, they saw lay intervention as potentially irrational and damaging" (Brown, et al, 1975, p. 100)

The central argument expounded is that in the case of the NHS the political elite (health authority members) is susceptible to pressures both from without and within the organisation, and that this pressure creates a sense of decision-making impotency. It would appear that the power brokers in the planning and policy-making process are the technical and administrative elites. A prime source of their influence is their ability to determine, or at least to manipulate, the 'need' for a particular service (Illich, 1978; Taylor, 1979; Wilding, 1982).

Technical elite - this group has a virtual monopoly on skills and knowledge. In the health sector, it is this group which provides the necessary care and services and, consequently, they are well placed to exert considerable influence over the policy process. Such influence is often expressed through their work place behaviour either by agreeing to implement a particular programme or policy, or by refusing to do so. In fact it is their use of the power of veto that is particularly telling in the policy process. The application of this power can be exemplified with the following quote from Perrin in his report to the Royal Commission on the NHS; "the exercise of clinical autonomy ought not to be allowed to extend to a veto on reallocation of beds to cope with changes in need. We came across a flagrant example of such a veto" (1978, para, B7.6).

Although composition of the technical elite can be construed to include all the professions involved in providing health care or services, in reality, it is the medical profession which dominates and characterises the behaviour of this elite. Thus the combination

described herein resembles very closely Alford's concept of the dominant or monopolist interest group, who have "nearly complete control over the conditions of their work" (1975, p. 194). This implies that they have a considerable degree of autonomy in determining how they organise their activities and that they tend to see issues either in terms of professional (and personal) satisfaction or as questions of esteem.

The medical profession often sees issues in clear unambiguous terms: namely that, as a demand exists for a service, a requisite number of beds and resources must be provided. Historically, as has been shown above, the medical profession has played a particularly dominant role in NHS decision-making and has been most capable of ensuring that the decisions obtained were compatible with their interests (Taylor, 1977; Haywood and Alaszewski, 1980; Illsley, 1980). Lee and Mills have observed that "despite the existence of the NHS planning system and provision for the systematic consideration of projects, planners had difficulty in combining the ability of influential clinicians to bypass the planning system and lobby decision-makers directly" (1982, p. 141).

It could be argued that this elite not only saw issues from a very parochial standpoint but paradoxically their position on any planning or policy matter was influenced by their observations and understanding of what the patient seemed to want or need. Thus it is not unusual for clinicians and other health care professionals to paraphrase their comments on a particular issue in such a way as to

suggest that they are speaking on behalf of the patient and not for themselves.

There is evidence to indicate that both factors - bypassing the planning system and purporting to speak on behalf of the patient - were manifest in the workings of the JPTE. Several of the clinicians concerned with elderly patients became impatient with the lack of progress and voiced their concern to higher authorities in an effort to move things along. The reason for this, in the opinion of a medical member of the JPTE, was because attention was directed towards those proposals and projects which would attract joint financing monies and not, as he argued should have been the case, concern with the overall health care needs of the elderly.

In contrast, medical influence over the developments procured by the JPTMH was largely negligible and can be considered to be a direct consequence of the lack of established services for the mentally handicapped. Put another way, there was not a cadre of clinicians available, capable of influencing, in a substantive way, the deliberations of the planning team. Indeed, this lack of medical dominance was one reason cited by a member of the planning team (a psychologist) as of particular relevance because they have no vested interest in the outcome and therefore adopted a much more positive stance in the discussions concerning a policy and plan for the mentally handicapped.

Administrative elite - their main responsibility, to put it simplistically, is to execute the decisions made and the policies

determined by the political elite. In other words, legitimacy for their actions comes from the politicians and yet, in the health sector, it has been argued that the politicians in the guise of health authority members are severely constrained in discharging their responsibility in a meaningful way (Alford, 1975; Haywood and Alaszewski, 1980). Ham has nicely captured the essence of the decision-making dilemma confronting the political and administrative elites when he noted that "where there are many different interests and where power is not concentrated in an individual or group, it is easier to prevent change than to achieve it" (1981, p. 197).

However, as Alford (1975) has clearly demonstrated, the administrative elite (corporate rationalists) are not a passive element in policy-making as they do exert some influence on the decision-making process through their ability, if not to control, at least, to interpret agenda items and also their skill and expertise in the analysis and dissemination (control) of information to health authority members. Although the role of the administration is generally a supportive one, they are not without influence which, in many cases, places them on a collision course with the technical elite because they both, to a certain extent, depend upon each other in order that any agreed decision can be implemented. That is why the relationship between the administrative and technical elites can be seen as either harmonious - working well together - or conflicting - encroaching upon each other's perceived territory.

It is worth quoting Parston at some length since the following passage in many ways encapsulates that special and poignant relationship which exists between planners (corporated rationalists) and clinicians (professional monopolists).

> "Questions regarding distribution of health care resources are legitimately open to the health services planner. Naturally, debates . . . . arise over how the resources and the services which they accommodate should be distributed. And these debates often embroil the planner in the arguments between providers and users of health services. After all, it is the providers of services - that is, physicians - who lend the authoritative professional weight to prescriptions of acceptable health services. Planners argue with physicians over how services are to be provided and, more frequently, who is to decide" (1980, p. 167-8).

The relationship between the main protagonists or elites in policy-making in the health sector is an uneasy one, borne of dependence, to ensure that policies do get formulated, agreed or accepted, and implemented. Thus decision-making in the NHS, of consequence, is diffuse and in many ways weak because "decisions taken at clinical level and defended by the principle of clinical autonomy create costs and de facto policies which impede planning and financial control" (Illsley, 1980, p. 95).

There is a burgeoning literature on professionalism and policy-making which not only considers the sociological viewpoint but also those from behavioural and organisation settings. Little purpose would be

served by reciting the vast array of literature on the topic as that is a major work in itself, however, at this stage it is worth a brief travel through the material in order to discuss some of the more significant features of professionalism and the manner in which they impact upon policy-making.

There is no doubt that professionalism, or the technical elite, is the dominant partner in decision-making in the health sector (Alford, 1975; Haywood and Aleszweski, 1980; Illsley, 1980; Ham, 1981). The reasons for this state of affairs is worth exploring because "the history of the British health service is the history of political power, ministers, civil servants, Parliament, accommodating itself to professional power" (Klein, 1974a, p.7).

Wilding in a powerful indictment of professional power puts forward three suggestions, in partial explanation, as to why decision-making in the NHS is particularly susceptible to the professional view.

> "Firstly, and most importantly, professional influence means that in many issues the decisions made serve professional interests rather than the public interest. A second indictment of professional influence is that it leads to services organised according to professional skills and ideas rather than according to client need. Thirdly, it means that certain elements and interest within the professions are able to dominate decision-making because of their greater prestige and status." (1982, p. 23)

The role of the technical elite or dominant professions in the health

sector could be characterised as 'power without responsibility'. They stress their altruism, arguing that tight controls would undermine their ability to respond according to each patient's needs. A fundamental concept which underpins their special relationship with the administrative and political elites is the inalienable belief in their right to define problems and determine need. It is this which is primarily the root cause of the tension and conflict with the administrative elite in the planning and policy-making process. Perhaps it is the professionals' Jeckyl and Hyde relationship with policy-making which accounts for much of this conflict and tension since, on the one hand, they wish to be seen as a group able to secure and protect their own autonomy, whereas, on the other hand, they are also dependent upon their relationship with the other elites in the system (Ham and Hill, 1984).

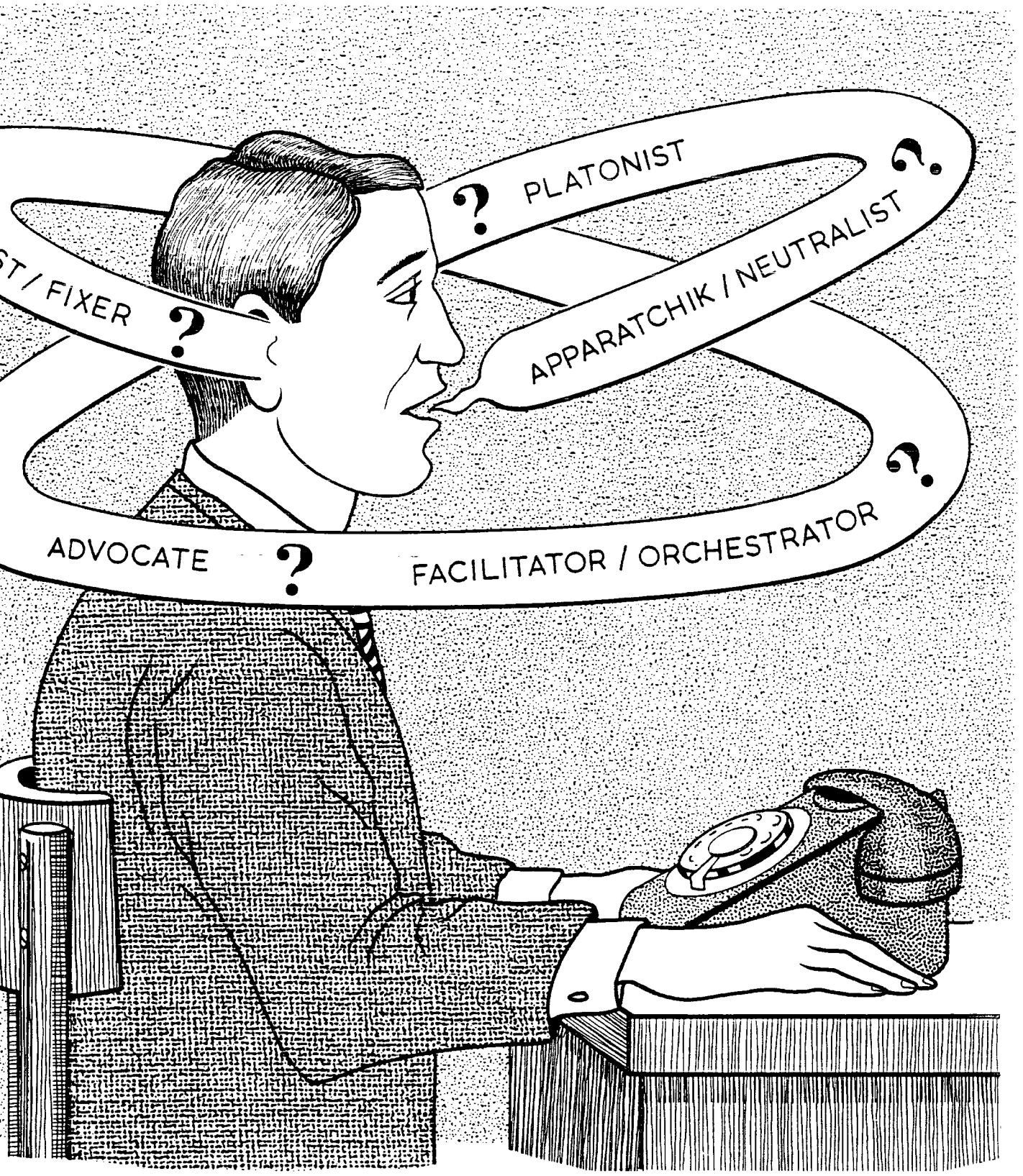
The planner as a representative of the administrative elite or corporate rationalisers is often characterised within the health sector as the main combatant of the medical profession. However, the planner, unlike the professional may have less prestige and status riding on his/her position and it is perhaps useful at this juncture to briefly review the various stances which a planner may adopt. In trying to identify who are the planners one immediately is presented with a dilemma in the sense that no one, yet everyone, is a planner. For the purposes of this paper it will be assumed that the planner is a public official, a bureaucrat, who possesses the title 'planner' or acts in a planning capacity. Consequently the roles they adopt are generally conditioned by their position in the bureaucracy that is the health service, and the values they hold.

Role of the Planner

Many planners/administrators tend to regard planning as a technical activity - whether or not a service was above or below a pre-determined standard or norm. To some extent the prescriptive nature of the NHS planning system precipitated this normative approach to planning, with its emphasis on planning according to the 'needs' of the population. Unfortunately as was indicated earlier (Chapter Seven), 'need' is a concept which is very difficult to define either qualitatively or quantitatively, thus necessitating some form of shortcut, such as standards or norms against which existing services may be compared. McNaught (1981) argues that the use of norms in planning is a consequence of a 'generalist cult' in the administrative hierarchy of the NHS, which implies that administrators should be capable of a variety of tasks and activities but not necessarily expert at any. McNaught goes on to suggest that planning should be removed from the bailiwick of the generalist and given to specialist planners (see also Rathwell, 1982).

If the logic of this argument is accepted at face value this raises many questions concerning the precise nature of the role that the specialist planner may play. How does the planner fit into this particular picture? There is no easy nor is there a definite answer to this question because the response depends, in part, on how the planner chooses to interpret and discharge the duties assigned to him/her, and, in part, upon the planner's own value system. Bearing these factors in mind, there are several views which can be promulgated on the role of the planner (figure 8.2).

Figure 8.2. WHAT ROLE FOR THE PLANNER ?



Platonist - the planner seeks to prescribe a good solution to the problem. This role equates with that pursued by such utopian planners as Howard and his concept of the garden city. This view of planning recognises no constraints or obstacles likely to inhibit the creation and implementation of the 'ideal' solution. One such proponent of idealised planning was Ackoff who argued that this was a valid approach because it "forces those involved to rethink each aspect of life" through the pursuit of "truth", "plenty", "goodness", and "beauty" (1976, p. 300).This form of planning while theoretically attractive has little following and in the health sector where resource constraints are the order of the day, it takes a particularly brave individual to champion something as unrealistic as the 'ideal'. Furthermore, critics argue that such an outlook on planning patently ignores the fact that planning as an activity operates within a conflict or power relationship (Parston, 1980; Ham and Hill, 1984).

Apparatchik - this type of planner is one who takes pride in being a good administrator with great emphasis placed on process and keeping within the stated regulations. The term neutralist has also been used to describe this sort of planner but apparatchik would seem to be a more apt description since the term is generally taken to mean someone who undertakes or carries out his/her duties without question. The role is then seen and interpreted in a non-political and non-controversial way. The concept of neutrality in the planner is central to any planning system based on the twin notions of 'rationality' and 'comprehensiveness'.

Satisfaction for this type of planner lies in doing a good job which in the health service has usually been interpreted as producing a good well-documented set of plans by religiously following the many steps and stages laid down by the NHS planning system (DHSS, 1976b). Thus planning is expounded as a technical activity within which there are certain conventions or rules to be followed and therefore any requests that accord with these rules are acceptable whereas those which do not are not entertained.

One of the strongest arguments for the planner as neutralist was promulgated in a paper by Davidoff and Reiner (1962) who argued that the planner is merely a technical resource either for the community or, more likely, for political leaders. What this means is that the planner neither imposes or even articulates his/her own views or opinions nor does he/she contribute to the goal setting process. Dyckman has interpreted this role as one which "operates in the absence of conventional profit motives, with the presumption that the planner will be sparing in the intrusion of his own values and will venerate 'objectivity'; and is first and foremost a community servant who will put the common good above self-interest" (1973, p. 244).

Most planners in the NHS would seem to be of this mould in that they see their duties as mainly those of making the planning system work and in many respects, but not all, the planners in Newcastle operated within this convention; that is of pursuing a rational approach to problem solving (policy-making) while maintaining political neutrality.

Facilitator/orchestrator - a planner who is keen to insure that planning works and consequently devotes considerable time and effort into 'making it happen'. The forte of this planner is the ability to lobby and generate support for planning through persuasion, striking deals or bargains, in order to ensure a successful outcome. Planning in this context is seen very much as a 'moral' activity in which there should be general support and it is the responsibility of the planner to engender that support.

This view of planning argues that the planner has a political role to play in the crusader sense where "the success of planning depends in large part on the ability of existing networks of influence to adapt and change to support planning programmes. Planners can make important contributions to this process not only in finding technical solutions to physical planning problems but also in creating a framework of support" (Rabinovitz, quoted in Faludi, 1973, p. 236).

The facilitator operates within the bureaucratic framework laid down by the planning system but obviously takes a more liberal view as to how the system should operate. From observations in Newcastle of the manner in which the planning process was undertaken it is difficult to be precise but there were indications that the facilitator role was an important influence upon the way in which the planners carried out their responsibilities. A good example of the facilitator role was the intervention by the planners, in the absence of any clear policy directions emerging from the JPTE, to prepare an outline strategy for the elderly articulated via the document The Proposed Temporary Closure of Walkergate Hospital (NAHA, 1981a). The 'Walkergate

Project' accomplished two things as far as the planners were concerned; it satisfied the bureaucratic demand for a plan, and it also served the purpose of breathing some life into what was otherwise a moribund approach to planning for the elderly. The 'broker-mediator' role is another phrase used to describe the activity whereby "in some decision-making environments, the planner must take a leading role" (Faludi, 1973, p. 236)

Advocate - a planner who cannot help being elitist in the sense that he/she purports to speak for a particular group of people or section of society. One of the earliest and most influential proponents of advocacy in planning was Davidoff (1965) who argued that the planner as advocate was one who helps a particular community or group to identify its particular needs, informs them of the choices or options available to them, lobbies decision-makers on their behalf and assists the group or community in preparing and articulating its own case or plan. When a planner adopts this particular role he/she "is no longer isolated from political activity; the planner makes political choices in a pluralist arena" (Parston, 1980, p. 56)

Proponents of the advocacy role proffer three grounds in support of such an approach. Firstly, it provides a means of informing the public of the choices open to them; secondly, it forces the particular agency (such as a health authority) or goverment to actively seek and compete for political support; and thirdly, it forces those who are openly critical of the establishment (health agency) to support or buttress their criticism by preparing alternative plans.

Hard line supporters of advocacy, such as Goodman (1972), put forward a forceful argument that planning in this context means that the planner assumes the role of society's policeman; that is, to oversee the process whereby the will of society is paramount. Put another way, the advocate role is to manage the development of society in a way that produces 'just outputs'.

It would be reasonable to say that those involved in planning in Newcastle did not see themselves as playing the role of the advocate as defined above. However, it does appear from the actions of certain members of the planning teams, certainly those comprising the common core membership, that they were not averse to becoming politically involved in an issue when they judged that progress was either not being made or that the debate was beginning to become tangential to the main theme. One member of the planning team for the elderly, a psychologist, stated that planners must act as advocates for the group they are planning for even though such a stance may well be difficult for some because of potential conflicts with their professional duty.

Fixer/Activist - this category has similarities to the foregoing in that the planner uses his/her position to secure certain objectives which, more often than not, have been defined and developed according to his/her own values. The label 'radical' could also be applied to this type of planner because "the activist view builds on the notion of a direct political role for the planner, but the activists reject the advocates' assumption of an egalitarian ethic" (Parston, 1980, p. 63)

There is a tendency in some of the planning literature to equate radical planning with Marxist ideology (Castells, 1973; Harvey, 1973; Milliband, 1977). Parston certainly gives the impression of having some sympathy with the Marxist view when he notes that "regardless of how the benefits of planning are distributed, it is to the profit of the capital-owning class to encourage town planning because planning helps to maintain existing production relationships." (1980, p. 69). Thus does he justify a more overt role for the planner to one who seeks "changes in the structural basis of society" (1980, p. 63). Having said this Parston recognises that in trying to accomplish this the planner is placed in a dilemma because, and especially in the health sector, the planner is beholden to the means of production - in short he is an employee - and as such may be reluctant to publicly push his/her views simply because his/her livelihood depends upon it. In other words, the planner as an employee is in an extremely weak position with which to foment social revolution. Fainstein and Fainstein sum up the problem very neatly when they state that "radical advocacy, from a marxist perspective, suffers from its co-optative tendencies, its negation of the planning function and transformation of planners into political agitators . . . and its inability to move beyond triumphs of veto and negation to orchestrate positive, system-wide movement. Guerillas in the bureaucracy are seen as weak and easily eliminated" (1982, p. 167-8).

There is a school of thought which, while not adhering to the radical advocacy of planning, argues that the planner can play a considerably overt role through his/her ability to maximise to the full the various resources available to ensure that a particular plan is not only

accepted but implemented. This was a view held by one of the planner-administrators who has argued on many occasions that resources, especially financial resources, are required to lubricate the planning process and that the hallmark of a good planner is his/her ability to secure or husband such resources and use them judiciously to promote or further a particular project, idea or proposal. As Petfield has acknowledged, "plans . . . without funds to give them effect are sterile" (1983, p. 113).

The Planning Process

Those involved in planning in Newcastle would hardly call themselves 'revolutionaries', indeed many would abhor the term and yet there were some who could rightly and properly be labelled as 'radicals' in that they were prepared to challenge the vested interests and to fight for the common good as they saw it. It would be misleading to suggest that the planners in Newcastle could be so easily pigeon-holed in the sense that any one of the foregoing descriptions could be said to be an accurate reflection of how they discharged their role. The reality is that the roles so described are manifest in several forms in that the planner seems to slip from one role to the other depending upon circumstances and the problem or issue to hand.

The difficulty with developing more sophisticated and specialised approaches to planning is that "policies are settled by bargaining between groups, with their own interest and frames of references, rather than by analysis" (Brown, 1975, p. 233). This is clear from the assessment of the JPTE and its membership, even though it appeared on the available evidence to be largely ineffectual in developing

policies and plans. However, the planner-administrators at NHA were equally constrained by the ability of certain groups within Newcastle to thwart the development of policies with which they did not agree. Eckstein (1956) has referred to this as 'bounded planning' because the planning process, and indeed those operating within it, do so within very tight boundaries, reflective of their own perceived values or concerns. In other words, the boundaries within which one plans are generally dictated by one's understanding or perception of the problem, the values which one holds, and one's susceptibility to the opinions and values of others. Consequently planners have very little control over the planning environment, as this is largely determined by the interaction of others.

Values play a very important role in planning in that they largely determine which issues are placed on the planning agenda, when, and in what form. Unfortunately there is little empirical evidence available on the impact of interest and values in NHS planning and policy-making, yet it is acknowledged as a key feature of the process (Alford, 1975; Parston, 1980; Haywood and Alaszewski, 1980; Lee and Mills, 1982). Haywood and Aleszewski while pleading for the implications of power and the concept of interest to be accorded greater prominence in any analysis of health care agencies offer little insight into what they readily acknowledge as this "uncharted territory." They do contend, however, that concepts extracted from the field of administrative policies may be useful in 'explaining' the different behaviour of those involved in planning and policy-making in

the NHS. This was a technique employed by Hunter (1980) in his study of decision-making in two Scottish Health Boards. The validity of applying theories of administrative politics as explanations for planning and policy-making as observed in Newcastle was discussed in Chapter Three and therefore the arguments need not be reiterated.

The issues discussed by both the JPTE and the JPTMH reflect, to a certain extent, the values held by the main protagonists, and it is reasonable to assume that the creation of a parallel planning group for the elderly was in part a response to differing values and perceptions. Commentators have argued that, unless the debate on policy is broadened to include notions of interest and values, it is most unlikely that policies truly reflective of patients' 'needs' will emerge (Haywood and Alaszewski, 1980; Mooney, et al, 1980). The evidence from the machinations of the JPTE and to a lesser extent the JPTMH does suggest that disguised or unarticulated values and interests did inhibit or pre-empt the search for common policies.

It is useful to compare the approach to planning displayed by each joint planning team as it sharply demonstrates the lack of continuity in planning in the NHS in general and at Newcastle in particular. It will be recalled that the JPTE produced very little in the way of proposals or plans for services for the elderly, despite a clear mandate to do so. It was left to the planner-administrators to produce such a plan, which they did primarily via a comparison of the existing range of inpatient facilities with that indicated by DHSS and RHA planning norms. The resulting plans were, in effect, a compromise

between the identified number of beds required to meet the shortfall and what could be reasonably funded, given the health authority's projected revenue allocations for the three-year planning period. This can be described as the application of a rather crude analytical tool to a complex issue.

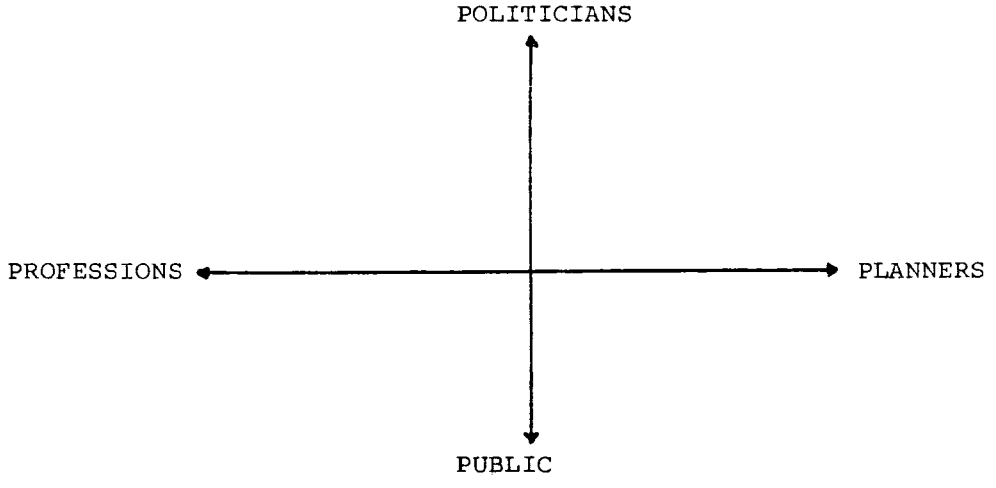
Progress for the JPTMH, or the Partnership which replaced it, was seemingly much easier, as there was no base with which to draw comparisons. As often happens in discussions, issues will arise, more by accident than by design, which by general consensus are considered to be 'worth pursuing'. It is unclear where or with whom the Partnership concept emerged, but once articulated it was rapidly endorsed as offering considerable scope for progress and there was a general will to carry it through. Thus it could be argued that planning in the NHS ranges from a near slavish adherence to central planning norms (Korman and Kogan, 1978) as a surrogate for a more analytical approach, to opportunism - the ability not only to recognise opportunities but also to exploit their potential.

Such diversity of interpretation and approach to issues has given rise to what some commentators have referred to as a conflict theory of planning. Basically what the theory suggests is that all the actors involved in the process do so within a state of conflict or tension, each with a particular position to safeguard and a certain philosophy to pursue. The inherent conflict or tension in planning and policy-making can be visualised as follows (figure 8.3), however as suggested earlier (this Chapter and Chapter Seven) most of the conflict would seem to occur between the three elites described above with the fourth

constituent (the public) a benign onlooker. This is not to say that the public is without influence in the policy-making arena; a topic which will be discussed in Chapter Nine.

Figure 8.3

Planning/Policy-Making as Tension



Wildavsky suggests that tension between actors in the policy process gives rise to policy problems and that the policies which are produced as a consequence of actor interaction are merely a "temporary and partial reduction of tension" because such "solutions are temporary in that the conditions producing the initial dislocation change in time, creating different tensions" (Wildavsky, 1979, p. 390). This view would appear to regard tension as an unreconcilable variable in policy-making and planning, a position shared by Barrett and Hill who noted that "there is a tension between the normative assumptions of government - what ought to be done and how it should happen - and the struggle and conflict between interest - the need to bargain and compromise - that represent the reality of the process by which power/influence is gained and held" (quoted in Ham and Hill, 1984, p.

112). This latter opinion would seem to encapsulate a rather optimistic note in that there is at least a proforma for reaching an agreement or consensus amongst the actors on any policy issues. In contrast the position adopted by Wildavsky is a more pessimistic one which sees conflict or tension as a precursor for planning and policy-making.

It could be said that the art of planning is conflict reconciliation rather than conflict resolution since the tensions which exist between the four constituencies may be suppressed where each component perceives that they will obtain a share or stake in the outcome. Thus "conflict may, therefore, remain latent if each has a share of the 'spoils'" (Lee and Mills, 1982, p. 75). While Lee and Mills acknowledge that the reconciliation of conflicting goals, values and interests is a major problem they do not really provide an insight into how this might be achieved, arguing instead that more research into this complex area is necessary.

There is no doubt that policy-making is an inexact science; if indeed it is a science at all, and although more knowledge and understanding is to be welcomed there is some evidence available to suggest that this area of research has not been neglected with some thought and proposals being proffered as to how the planner can undertake a more proactive role in the planning process (Parston, 1980; Dear and Taylor, 1982; Mohan, 1984).

The crux of the arguments propounded by Parston (1980), Dear (1984) and Mohan (1984) is that planning and policy-making is a state

activity and as such is directed towards the fulfillment of the state's administrative and legitimate aims. Parston (1980) sees both the planner and the provider as agents of the state; the former as a pawn whose job is to put the state's wishes into practice through the production and publication of plans and programmes which embody and justify the wishes of the state. The latter (providers, especially the physicians) plays the role of legitimiser by distinguishing between physical disability - regarded as a legitimate ailment, in the sense that the reason for lost production is a visible one - and psychological illness - the worker is not often regarded as being truly sick but one who is work shy and consequently "a parasite on the capitalist back".

Dear demonstrates considerable dis-enchantment with what he calls the "well-worn ruts" of health services planning, with "each bearing relatively little reference to the other or to the wider context of illness and health" (1984, p. 8). He bases his stance on empirical evidence arising out of a study of psychiatric services in Toronto (Dear and Taylor, 1980). He argues that there is a need for "a proper theory of health care systems (which) must accommodate the reflexive nature of the concepts of illness and health" (Dear, 1984, p. 9). Such a theory, according to Dear, should have three primary foci: the historical development of the health care institution because its origins rest within the evolution of capitalism; the construction and application of health care which sees health primarily as a commodity regulated by the state; and, the political context of health care where the relationship between the state and the health care professions is in a continuing state of flux.

The role of the state in the planning process is a theme which is echoed by Mohan (1984). He concludes from a description and analysis of hospital planning and new town development in the north-east of England that there are three issues in which the role of the state is important. The first concerns the degree of flexibility (or rather the lack of it) indentured in the state which is usually constrained by financial circumstances and shifting professional attitudes to policy. The second factor is the discord between various state agencies whose ability to intervene in issues is governed by legislation thus placing some agencies in a subservient role to others, leading to a divergence between problem definition and policy formulation. The third factor affects the approach to policy formulation by the state and its agencies. In essence Mohan argues that policies are developed not in a "systematic or co-ordinated pursuit of state objectives" but " as a series of ad hoc responses to changing socio-political and economic circumstances" (1984, p. 159).

There is little dispute about the attractiveness of the message being purveyed by advocates such as Parston and Dear, for the planner to play a more interventionist role and that planning issues should be placed within a wider context. The ideological commonsense of such an approach has much to recommend itself, but what is generally lacking is a mechanism or formula for putting into practice that which is preached. This is a failing which can be unequivocally laid at the feet of Parston (1980), Dear (1984), and others who offer a concept without constructs. One is left, therefore, to fall back on the methods and mechanisms which these authors deride in order to give

some explanation of why and how policy-making and planning functions as it does.

It is generally accepted that the measure of success in planning and policy-making is whether or not the desired measures are implemented and in the form originally agreed (Pressman and Wildavsky, 1973; Lee and Mills, 1982), because this is the stage whereby policy is translated into action. If this is the case then successful implementation depends upon two crucial elements: organisational knowledge; and, determinate power. Or, as Lee and Mills have put it, "successful implementation depends first on knowledge of behaviour and circumstances both within and outside the organisation and of the resources available, and second on the power to carry through decisions" (1982, p. 166-7). Understanding these elements is therefore crucial for the planner and policy-maker otherwise to ignore them would "doom to irrelevance" any outcome of the process.

Organisational knowledge is important because if one is not familiar with the intricacies of the health care system it is most likely that the various power bases or factions would remain relatively unidentified with the consequential outcome being more or less predictable; general intransigence to change. Also relevant is an understanding of the relationships which exist between the various power blocks (elites) thus enabling the planner to undertake a brokerage role by ensuring that the support of those essential for a positive outcome (implementation) is actively pursued. Closely allied to this bedrock of organisational knowledge is the ability to not only identify but also to procure resources; in particular financial

resources. This may be difficult in a climate of economic retrenchment, but not necessarily impossible. As one planner/administrator in Newcastle put it, planning is about the use of money in order to invest in change.

Determinate power is about knowing who can help and who can hinder the planning process. It is, of course, more than just a question of seeking and building alliances or networks within the organisation, it is also about negotiation and bargaining. This is a theme which Barnard et al espouse when they noted that "health planning is necessarily the subject of adaptation, compromise, bargaining and reconciliation of conflicting interests" (1980, p. 263). This implies that planners must develop a better than average understanding of the political processes which govern planning and policy-making if they are to have any chance in ensuring that the outcome of planning is effective action.

At the root of planning and policy-making is the individual and it is the role of these individuals and how they interpret the organisation's rules and goals which, according to Lipsky (1980) determine the policies which are carried out. Lipsy terms the manner in which such persons discharge their responsibilities as "street-level bureaucracy". His description of street-level bureaucrats is of workers who "believe themselves to be doing the best they can under adverse circumstances and they develop techniques to salvage service and decision-making values within the limits imposed upon them by the structure of the work. They develop conceptions of their work and of

their clients that narrow the gap between their personal and work limitations and the service ideal" (Lipsky, 1980, p.xiii).

Lipsky's concept of street-level bureaucrats is a useful analogy with which to explore the approach to planning and policy-making as exemplified by NHA. One of the main distinguishing features differentiating between street-level bureaucrats and managers is that they operate to different job priorities. The clinicians right to provide the best available care for his/her patient contrasts with management's desire and concern to see that such care is furnished in an efficient and effective manner so that many benefit. There is also the added factor that street-level bureaucrats are in the front-line when it comes to dealings with the public whereas managers usually are not. This creates additional problems because the former has to bear the brunt of public criticism while the latter is one step removed and perhaps may be less appreciative of the pressure placed on the street-level bureaucrat. This may in part account for the fact that when the street-level bureaucrats (professionals/technical elite) are co-opted onto a planning team they become very reluctant to rock the proverbial boat preferring instead, as the JPTE demonstrated, to create the appearance of doing something but, in reality, doing little. Thus discussing the potential local implications of national policies is a good exercise in "blame diffusion" because any unpleasantness arising out of said policies can be firmly laid at the door of central government.

Another and related feature is the desire of street-level bureaucrats to expand their autonomy. The growth of professionalism and the

fragmentation of larger professional bodies into sub-divisions or specialties within, such as medicine and to a lesser extent nursing are cases in point. In the main the argument here between managers and street-level bureaucrats is over discretion. "Managers try to restrict workers' discretion in order to secure certain results, but street-level bureaucrats often regard such efforts as illegitimate and to some degree resist them successfully" (Lipsky, 1980, p. 19). One medical member of both the JPTE and JPTMH commented that although there should be negotiation between clinicians and planners on how things could/should change or develop, ultimately doctors have the final say on what changes will be implemented. Needless to say, one of the planners/administrators saw things differently by noting that management was expected to do their job but in doing so was not to challenge the professional's right to provide care even though the two perspectives may, and often do, conflict.

What Lipsky has provided in his study of street-level bureaucracy is an insight into the environment within which bureaucrats operate "where relationships between policy deliveries and managers are conflictual and reciprocal" (1980, p. 25). Understanding and accepting this as fact is an essential and necessary ingredient for planning and policy-making - the counter balancing informal element inherent in any formal planning procedure.

The informal approach to planning and policy-making operates on a different plateau from the formal method but they both nevertheless share the same objectives. The emphasis here rests not so much on the procedural but instead on the personal - a matter of good

relationships being established between all participants. Planning is essentially the art of negotiation and while some negotiations can be conducted by committees (planning teams) there is generally little pressure on individuals to accept, unequivocally, the decisions reached by committees. The informal mode of planning and policy-making puts the onus on both the provider of care (technical elite), the planner (administrative elite) and the policy-maker (political elite) to identify and share what each sees as important on any issue under consideration. The distinct advantages of this approach are considered to be a more constructive involvement in planning and policy-making instead of the more usual reactionary responses obtained hitherto. It is of benefit to both planners and providers to understand the values, interests and assumptions which underpin their respective positions.

Whatever mechanism is applied or preferred the participation of both providers and planners is important and essential if any changes in the pattern of services is to be achieved. Thus it is important that the providers of health care understand and appreciate how the NHS planning system operates so that it can be employed to the best advantage. Health planners and policy-makers are not omnipotent - they are often not aware of what the problems really are; indeed, they are only as good as their information about, and understanding of, the relevant issues, how they see these issues being dealt with, and their perception of the political framework within which they plan. The providers of services also contribute to the overall picture of health care but they too tend to see issues or problems in

a particular way, a course often coloured by their specific professional roles and responsibilities.

If policy-making in the NHS can be likened to assembling a large jigsaw puzzle for which the guiding picture has been lost, then the provider and planner are natural allies, because of their specific talents, to be given the task of solving the puzzle. There is, however, an additional player who, although often excluded from the game, does have a legitimate claim as a player - the public. The role and contribution of the public in planning and policy-making is the major theme of the next Chapter (Nine) which considers the important issues of consultation and collaboration and policy formulation.

CHAPTER NINE

PUBLIC INVOLVEMENT IN THE PLANNING PROCESS

Throughout the foregoing discussions on the various roles and responsibilities assumed by both planners and policy-makers and others it has been implied that there is a degree of dependency between the various groups or actors involved, even though such dependency has only been referred to through the use of terms such as 'consultation', 'collaboration' and 'participation'. Equally implied, but not stated, was the assumption that those involved in planning and policy-making do so on a fairly equal basis with each having a reasonable opportunity to influence the outcome of the process. As has been seen earlier (Chapters Seven and Eight) there are certain groups who are competing, both overtly and covertly, for a greater voice in the planning process while others, as a consequence of this agitation, are often regarded as mere pawns (Alford, 1975).

This chapter explores the consultative and collaborative relationship between the various actors in the planning process especially as it applies to joint planning and in particular the role of the public in the planning process. This will be discussed within the context of public participation in general and its specific application to the health service. It should be borne in mind that although the terms 'collaboration', 'consultation' and 'participation' are in effect used to denote 'involvement' in the policy-making process it does not follow that each has the same connotation, nonetheless, it is both important and necessary that each of these concepts are clearly understood.

Consultation and Collaboration

One of the key features of the NHS reorganisation in 1974 was the desire to facilitate joint discussions between the health authorities and the corresponding local authorities. Indeed, the legislation which constituted the then AHAs enshrined such co-operation through the establishment of Joint Consultative Committees (JCC), composed of health authority members and local authority councillors. Additionally, and equally, important was 'coterminosity' whereby the AHAs and their local authority counterparts shared the same geographical boundaries. Collaboration was seen as providing a cornerstone in relations between the NHS and local authorities, under the terms of the 1974 reorganisation of the health service. The vehicle through which this new relationship was to be cemented was the JCC. This new body was one of the recommendations contained in the report of the Working Party on Collaboration between the NHS and Local Government (DHSS, 1973). The rationale underpinning the Working Party's recommendations was stated in the following manner; "that the real objective is not to achieve the joint consideration of plans which have been prepared separately by the two sides and brought together at a late stage to see how well they match up. It is, rather, to secure genuinely collaborative methods of working throughout the process of planning, and close and continuing co-operation between the officers of the two sides" (DHSS, 1973, para 4.9).

The emphasis was on collaboration, a concept defined by Chambers' dictionary as "to work in association with". Lee and Mills offer a more detailed definition of collaboration which to them "implies that

the organisation or groups in question have equal rights to be involved in the formulation of each other's goals and in their achievements where there are matters of mutual responsibility, concern and interest" (1982, p. 129). This concept was one which was shared by the DHSS and was articulated to both health and local authorities in a circular on joint care planning (HC(77)17/LAC(77)10). The government's views were stated as follows:

> "The Secretary of State's aim is to encourage joint planning by health and local authorities in which each authority contributes to all stages of the other's planning, from the first steps in developing common policies and strategies to the production of operational plans to carry them out. Only by full collaborative planning in partnership can health and local authorities devise and implement effective complementary patterns of services." (DHSS, 1977b, para 1.1)

It will be recalled (Chapter Five) that the JCC was the umbrella body under which the JCPT, composed of officers from both health and local Authorities was created to oversee the planning functions in which both had an interest and involvement. The JCC, however, did not have executive powers, it was only an advisory body, despite its legal constitution. Its creation was designed to ensure a close working (that is, collaborative) relationship between health and local authorities, in the hope that by doing so a clear lead by the members of both Authorities would emerge which would guide and sustain a commitment to joint policy-making. What evidence is available would suggest that the JCC was largely incapable of fulfilling its original function (Lee and Mills, 1982; Glennester, et al, 1983).

Consultation, according to Chambers' Dictionary is "deliberation, or a meeting for deliberation" which although useful does not help to shed much light on the process. Ham has defined consultation as an activity which occurs when "a group's views are actively sought and may or may not be taken into account" (1980b, p. 223). Lee and Mills extend this definition to "the seeking of advice, information or opinion, without a commitment to follow views received, and with the consulting body responsible for the final decision" (1982, p. 129). Thus, negatively, it could be argued that consultation is essentially a one-way process in that the consulter is seeking to have his/her opinion confirmed and therefore is not really seriously interested in the opinion of the consultee, should that opinion be perceived or interpreted to be somewhat critical. Positively, it can be argued that consultation creates opportunities for corrective processes, for example, by eliminating errors, raising previously unacknowledged aspects or issues, and so on.

'Consultation' as seen by most health authority's planners consisted of distributing copies of the draft plans to all those bodies who may have had an interest in the plans, with an invitation to comment upon the contents therein. (In other words, consultation was restricted to information sharing and did not extend to participation in decision-making). The comments received through this procedure tended to fall, in the eyes of the planners and policy-makers, into two categories: frivolous - raising questions of detail rather than of substance; or non-response - little in the plans were seen to be of direct interest or not enough time was given to prepare a proper response because of a short consultation period. As a consequence, the value of

consultation has become rather discredited in the NHS, because it does not provide the response which the planners seek which is an endorsement of their perception of how and in what manner the health service should progress. Thus, to a certain extent consultation is the bete noire of NHS planners and policy-makers because it is something which they are obliged to do but to which they carry little commitment.

This bureaucratic approach to consultation could partially explain why very few health services plans are implemented. The answer may rest with the limited involvement in the production of the plans of those responsible for providing the service. As Lee and Mills (1982) observe, the professions, particularly clinicians, expected their views to be unequivocally accepted by planners and policy-makers and therefore there was little enthusiasm on the part of doctors to participate in the advisory machinery which they regarded as a tedious chore. This ambivalent attitude to being involved in the planning process was reflected by comments received from two clinical representatives of the common core of members to both the JPTE and JPTMH. Both were specifically asked for their respective views or opinions on the value of consultation. Interestingly, neither of the clinicians interviewed regarded consultation and their participation in the mechanics of it as being particularly useful. One attributed his position to the fact that the planner and the doctor spoke different languages. This was ascribed to different perspectives - the clinician saw planning as a hobby and therefore divorced from ordinary clinical work, whereas it was the raison d'étre for the planner. Ergo, it could be argued that doctors have better things to do. The

other doctor had no opinion whatsoever to offer on the value of consultation other than to imply that the existing advisory committee structure played a useful supporting role to the established planning system.

An additional factor is that it is uncommon for either the CHC or the public to be represented on the planning team thus making it difficult for the criteria to be satisfied of plans appropriate to the 'needs' of the population. Both the JPTE and the JPTMH followed the traditional NHS approach to consultation - comments were invited after plans had been formulated (that is, after the event rather than during). Furthermore, the membership of the planning teams was composed of health and local authority professionals, with the majority from the health side; no lay persons or CHC representatives were involved in the area under scrutiny. This situation did not hold for the Partnership which replaced the JPTMH (Chapter Five), a subject which will be returned to later in the chapter.

It is debatable whether the inclusion of a CHC representative on the planning teams would have improved the end result of the process. As Lee and Mills have commented from their observation of planning in the NHS, "there was little evidence that the consultation process . . . had led to any significant change in the balance of power" (1982, p. 143) towards the CHC. Even the much lauded efforts in the United States to bring citizens into the health planning realm has received mixed reviews which has led Checkoway to observe that "the future of health planning and consumer participation is uncertain" (1981, p.

10), because instead of opening up the policy-making process it has paradoxically concentrated "power among selected providers committed to traditional medical practice" (p. 9). This view is supported by Riddick, et al (1984) who in a study of consumer involvement on the board of a Health Systems Agency, noted that despite having a majority of members, consumers were not able to exert a controlling influence over the decision-making process.

Having said this, and even though the medical profession appeared to have little use for consultation, it was seen as an important issue both by the planner/administrator member of the common core, and perhaps less surprisingly by the secretary of the local CHC in Newcastle. The secretary disclosed that the CHC had been offered observer status on the JCPT but the CHC declined the offer because it did not alter the existing situation by allowing them an early involvement in the discussion stage of planning. Thus the goal of the CHC remained - to be an equal member of the health authority's planning and policy-making process.

Participation

It is appropriate at this stage to consider the question of participation since many commentators regard it as crucial to the whole debate over policy (Simmie, 1974, Fagence, 1977; Broady, 1979; Glass, 1979; Boaden, et al, 1982). The problem with participation is that it is much more difficult to settle on an acceptable definition than it was for 'consultation' and 'collaboration'. Much, but not all, of the debate about participation is couched in terms of democratic theory which essentially sees participation as an integral

component of any democracy (see Pateman [1970] for an excellent discussion on this topic). Inherent in the concept of participation, especially that grounded in democratic theory, is the notion of collaboration and consultation - a classification to which Ham (1980) also includes articulation and public relations. Interestingly, Ham in offering such a typology argues that there is little or no correlation between these notions of involvement and the degree of power exercised by decision-makers. Thus Ham's classification of forms of public participation, though of interest, is not particularly helpful.

A much more informative tabulation of various forms of participation has been posed by Arnstein (1969) in what she called a 'ladder of citizen participation'. In her concept of the way these types inter-link, she parts company with Ham since she bases her different notions of participation according to the degree of citizens power which appertain. Arnstein's terminology is as follows:

Citizen Control

Delegated Power

Partnership

Placation

Consultation

Informing

Therapy

Manipulation

It will be obvious from this taxonomy that Arnstein's perception of participation implies a hierarchical order or range comprising eight elements sub-divided into three stages or rungs, representing in ascending order of importance, non-participation, tokenism, and citizen power.

The first rung of the ladder (non-participation) requires some explanation in order to differentiate between 'manipulation' and 'therapy'. The former occurs when the public are given places on advisory bodies which function primarily as a 'rubber stamp' agency. This was what was offered to the CHC in Newcastle - membership in the form of observer status on the JCPT - when they persistently pressed for a say in the planning and policy-making process. The latter refers to attempts to 'educate' the public that the policy-makers always have the 'best interests' of the public upper most in their minds when formulating policy.

The second level (degrees of tokenism) describes different degrees of involvement and is probably most indicative of the current state of participation in the NHS. 'Informing' is a marginal improvement on 'therapy' in Arnstein's model although there appears to be little to distinguish between them. If there is anything between the terms, it is suggested that informing does, at least, allow for the possibility for the feedback of views whereas 'therapy' clearly does not. The relationship between the JPTE and health authority planners could be said to be of the 'informing' category since the planners prepared and produced plans for the elderly separately from the planning team who

were not consulted and therefore played no part in the process. They were merely informed of the outcome of the planners efforts.

'Consultation' is considered to be one of the key planks of the NHS planning system whereby there exists a specific procedure for ensuring that interested and concerned parties are consulted about the plans and policies produced. Thus there is an impression of 'real' involvement in the planning process and yet it is a false promise because, although the planning system provides a mechanism for consultation, it offers no assurance that any views profferred will be given any credence and taken account of. This is standard practice in the NHS as Lee and Mills (1982), Glennerster, et al (1983) and others have observed. Perhaps the attitude to consultation in the NHS can best be summarised through the observations of one of the principal planners of NHA who, while acknowledging that consultation is important, argued that in the end it was the views of the administrator/planner which took precedence simply because they were paid to manage the services whereas the others were not.

The final element, 'placation', on the tokenism rung refers to the practice of nominating members of the public to sit on executive boards such as local health authorities or where citizen committees are created, such as community health councils, and given an advisory role without any real power to influence the policy-making process. A discussion of the impact and influence of lay members on executive bodies such as health authorities is beyond the scope of this chapter, and has been touched on earlier (Chapter Seven) however, there is sufficient if limited evidence available to suggest that the public

member of such bodies play only a very minor part in policy-making (Hunter, 1980; Ham 1981; Haywood and Alaszewski, 1980). The reality of planning and policy-making is that it is the professionals (technical) and the administrative elites who dominate decision-making in the NHS.

The final or upper tier (degrees of citizen power) represents in many ways the ideal or utopian dream, and like all utopias, attainment is questionable. There is no evidence in the health service that the top two stages, 'citizen control' and 'delegated power' have been, or are even likely to be achieved. There is a situation whereby a CHC may be in a position analogous to that of 'delegated power' - decision-making authority and veto - which can occur when a health authority wishes to close permanently a hospital or part thereof. When this is the case, the view of the relevant CHC must be sought and it is here that the CHC has power of veto over the closure proposal insofar as it, at the same time, puts forward an alternative plan. If a satisfactory solution or compromise cannot be reached, the matter is forwarded to the Secretary of State for Health and Social Services for a final decision. This decision process is a power which seldom results in the CHC proposals prevailing (Hallas, 1977). Subsequent modifications by the DHSS have altered the circumstances and procedures by which CHCs can exercise their veto over hospital closures (De Peyer, 1979).

The one remaining element in Arnstein's typology is 'partnership' which she sees as a form of power through negotiation. Negotiation in this context refers to a situation whereby the outcome of the policy-

making process is contingent upon the agreement of all parties concerned. It is clear from the available evidence that the Partnership conformed to the 'partnership' component in Arnstein's package, even though the earliest attempts to constitute the Partnership did not envisage equal sharing of power between health authority, local authority and lay representatives, since the lay proportion was very much in the minority (Petfield, 1983). Subsequent outcries by the lay members succeeded in the granting of equal status to all parties, which meant that any plans or policies produced by the Partnership emerged as a consequence of negotiation rather than consultation.

Arnstein's 'ladder of citizen participation' is a useful but imperfect way in which to examine various attempts and degrees of participation in the NHS. However, like many typologies the categories or types which she distinguishes and describes are not necessarily self-evident; that is to say, it is not that easy to be absolutely certain that an activity cast as 'informing' is not merely 'manipulation' in another guise. Thus it could be argued that Arstein employs too many examples which gives rise to classification problems, some of which arise from a different interpretation of meanings between US and UK cultures and, therefore, a simpler paradigm would be more useful. Such a model is one discussed by Pateman (1970) who identified and described three forms of participation; pseudo, partial, and full. The first type - pseudo - is defined as a process in which no participation in decision-making actually takes place, instead under the semblance of participation, management consults with its employees and others in order to persuade them to accept decisions which have

already been made. Much of the so-called participation in the NHS planning system by non-NHS bodies was of this type. Indeed, there is some evidence to suggest that those within the NHS who were not privy to the planning and policy-making process were treated in as equally a cavalier fashion as their non-NHS contemporaries (Haywood and Alaszewski, 1980; Ham, 1981; Lee and Mills, 1982). This approach is consultation in its more literal interpretation where the planners and policy-makers seek views in support of their own preconceived position as outlined in the plan or policy document.

The second element - partial participation - describes a situation in which those who are party to a decision have some influence over the final outcome. Such influence is partial because usually only one party has the final say on what will happen. In the case of the NHS the deciding party is generally management. A good example of this form of participation has been the discussions and consultation surrounding the publication by the Oxford Regional Health Authority (ORHA) of a paper spelling out the implications for the Region of recent changes in Government policy (ORHA, 1982). The paper called for very radical changes in the manner in which health services were currently being provided in Oxford and was sent out to a variety of agencies and groups for their comments. The consultation procedure and its general consequences have been well documented by Hallas (1985) and therefore will not be elaborated on here. What is of interest though is the outcome of the consultation process which led to a 'revisionist stance' on the part of the ORHA. In a subsequent statement by the authority (ORHA, 1984) it publically acknowledged the contribution made by doctors, nurses and administrators to the revised

plan. However, "in terms of formal consultation with representatives of the general public, to those nearest to this aspect (the CHC) the consultation was derisory" (Hallas, 1985, p. 94). Thus partial consultation within the context of the NHS indicates that the ability to influence plans and policies rests with doctors, nurses, and administrators, whereas the public in the guise of the CHC is attributed no power or influence at all - shades of pseudo-participation.

The third and final component in Pateman's trifurcation is full participation; "a process where each individual member of a decision making body has equal power to determine the outcome of decisions" (1970, p. 71). This is something of a rarity in NHS circles, especially that relating to planning and policy-making of which the Partnership is very much the exception with influence and decision-making power invested in a troika of NHS, local authority, and lay representatives. The Partnership with its tripartite structure (see Chapter Four) provides a good example of the way in which the mix of professionals and lay people can produce results.

There is some limited evidence available to support the contention that the inclusion of CHC members and/or lay people in planning does improve the quality of the product (Jones, 1977; Ham 1980; Hallas, 1985). This has, undoubtedly, been the case with the Partnership, as the following event illustrates. One of the earliest issues that the Partnership faced was whether to supplement the existing nucleus of a Community Mental Handicap Team (CMHT) inherited upon their incorporation, or to search for and establish a Family Resource Centre

(FRC) as a base from which the Partnership would be administered, parents and the mental handicap could turn to for advice, and the professionals would operate. Both issues were seen as important as defined in the Blueprint for a Local Service' (NAHA, 1981b) which outlined the rationale for the Partnership and the policy issues which were to be pursued.

There was considerable debate amongst the Partnership members over which of these issues should take precedence and also over what should comprise the CMHT and the FRC. The professional element on the Partnership, while recognising the need for the FRC, argued for an increase in the CMHT on the grounds that this would meet an immediate service need. The lay constituents were not entirely convinced by this argument, suggesting in turn that the FRC should proceed first, since there had been only a very minimal service in Newcastle for the mentally handicapped with which parents and supporters had had to contend. The lay members believed that they could wait a little longer for professional support whereas what they really needed was a place where they could go for comfort, relief, short-term support, a forum to discuss problems and so on. What, in short, the lay members were saying was that they required early on in its development a concrete sign that the Partnership was about change, new approaches, and that the parents were considered to be an integral part of this new initiative.

The outcome of this testing of the managerial waters was in many senses the classical compromise in that the FRC was considered to be top priority but at the same time steps were to be taken to bolster

the staff resources for the CMHT in order that it could fulfil the tasks defined in the 'Blueprint'. Thus the desirability of the lay persons on the Partnership for a central focus for mental handicap in Newcastle triumphed but the professionals had not necessarily lost their case since coupled to their support for the FRC was a request for more nursing resources for the CMHT. A request which the Area Nursing Officer supported, and offically asked that this petition for additional nursing staff be borne by NHA and not from the Partnership funds, although there was some reluctance initially to pursue this option.

The difficulties facing the Partnership in attempting to reconcile various competing demands on its resources and still retain faith with its inaugural policy document (the Blueprint) were aptly described in a memorandum from the Health Authority's planning officer to his superior:

> "The partnership cannot be expected to maintain its course in pursuing the priorities identified in the Blueprint . . . in the face of very strong pressure from professional staff for 'more and more'. There is no doubt that psychology and nursing resources seem incredibly low and in need of strengthening but they needed this before the Partnership came on the scene. I think what we are witnessing is an admitted frustration from the professionals in being unable to obtain additional resources from existing budgets. They naturally are attracted therefore to what they see as 'free' money. The Partnership is simply not able at this point in time to assess their needs"

In the end, a proposal was put to the NHA that three additional community nurses for the mentally handicapped should be appointed and supported by Health Authority funds and not from Partnership monies.

Problems in Participation

As the preceding discussion has clearly shown there is no sustained drive either within the NHS or the Local Health Authority to augment the intrepid steps taken by the Partnership down the 'unadopted' road of public participation. It does appear in the NHS that it is the "administrative perspective" rather than the "public perspective" (Glass, 1979) which rules the day. The 'administrative' perspective is an approach to participation which is, in essence, illusionary. That is, participation is viewed as a tool or device through which an organisation informs the public that it has its (the public's) best interests at heart and that the policies and plans published by the organisation reflect this (Hallas, 1979). A sort of benign benevolence in that the goals of the organisation, and to a certain extent those employed within it, are dressed up to give the appearance of emanating from public concern. The 'public' perspective occurs when an organisation actively involves the public in the determination of policy.

The choice of either the 'administrative' or the 'public' approach to participation is not a straightforward one. The dilemma is that both the organisation and the public have particular requirements to be considered and these requirements are usually dissimilar in their objectives. Thus to follow the 'administrative' approach may satisfy the requirements of the organisation but alienate the public; whereas

the 'public' approach is often confounded by the knowledge that there is no iron-clad procedure for determining what purports to be the public's view (Fagence, 1977). There is also a further complication to consider; namely that the public and those responsible for the planning of health services may not share the same goals and values for subsequently improving services. For instance, providers of health services may regard better working conditions, improvements in medical technology, concentration of services on one site and the professional development associated with this concentration as providing positive benefits for patients and would, therefore, value highly such improvements. Whereas the public may regard improvement in health care of value if it increases accessibility to health services, provides a reasonable range of services locally and does not threaten the existence of their local hospital. Such differences, while not irreconcilable, do require considerable negotiation if controversy is to be avoided, as the debate in the Partnership between a resource centre or extra nursing staff aptly demonstrates.

Another aspect which often inhibits the acceptance of participation from the point of view of the planner, is the so-called 'fickle' nature of the public. The public, for example, generally desires the best health care available, but at the same time it is often unwilling or unable to contribute towards better health care by accepting some degree of responsibilitiy for its own state of health. For instance, there is a growing body of evidence which suggests that there is a causal relationship between smoking and the increase in the incidence and prevalence of cancer and respiratory diseases (Vessey and Gray, 1985; Alderson, et al, 1985), and yet substantial numbers of the

population continue to smoke inspite of the obligatory 'health warning' on all cigarette packets.

It is often claimed that it is in the best interests of the planner and policy-maker to foster and encourage the involvement of the public in the planning process (Simmie, 1974; Bailey, 1975; Fagence, 1977; Broady, 1979; Checkoway, 1981). The rationle for pursuing this task is generally simple: it is easier to effect change if all those affected are involved in the debate about the direction and manner such change should take. It is assumed that by reaching an accord or accommodation on the main issues there would be a consensus amongst those concerned to put the plans into operation. This has generally been the case with regard to professional and administrative roles in decision-making but, as has been shown, rarely applied to lay or consumer interests. And yet, the limited evidence presented does suggest that there are a number of compelling reasons for broadening out the policy-making process to include the public.

Firstly, people in social classes I, II, III are often more articulate and better-informed about health care today than ever before and, consequently, are very interested in and concerned with policy issues, especially those they perceive to have direct relevance to them. Providers of health care, for instance, often see issues in terms of resources (usually a lack thereof), whereas the public's concern is usually of a different order, less to do with the availability of resources, rather more anxiety about access to services; quality of care available; responsiveness of health personnel; and, the impact upon the family of particular health problems (Ellenburg, 1981).

Secondly, there are those in any community who are very well-informed about the community and its 'needs', and it is important to try to 'tap' this pool of knowledge. The creation of the CHC in the health service was, in part, designed for this purpose (DHSS, 1975) and as both Hallas (1979) and Ham (1980) have observed, CHCs have had some success in influencing planning and policy-making in the NHS. Indeed, the experience of the CHC in Newcastle also demonstrates that the CHC is not without influence, but their ability to effect change would appear to be limited to circumstances or issues where there is little or no professional connections or power base such as with the mental handicap.

Thirdly, there is a school of thought which argues that it is better to involve the public (or at least their 'representative') in planning and policy-making rather than exclude them, on the grounds that by bringing such groups closer to the planning process it is they and not the planners who often become the more amenable. This is not to say that it is a one-way procession only; exposure to different perceptions held by the public undoubtedly leads to a modification of professional views and opinions. Again this change in positions was evident from the machinations which occurred within the Partnership and the policies which it adopted, whereby a difference of opinion between professionals and lay people over priorities was resolved amicably (Petfield, 1983). In short it could be argued that commitment to the ideals of the Partnership overcame the desires of certain groups within it. This approach to decision-making accords very closely with the Japanese style of management outlined by Ikegami

as "the mutual effort made by both management and workers to gain commitment to the organisation" (1985, p. 41).

The fourth and final factor is based on the concept or philosophy currently in vogue in management circles and stems from Peters and Waterman's (1982) influential book, In Search of Excellence in which they outlined their reasons as to why the top companies in the United States were so successful. One of the major factors cited was that these successful organisations had specific policies which could be collectively referred to as "getting close to the customer". The Peters and Waterman formula is very similar but not identical to that advocated by Ikegami through his concept of Gemeinschaft whereby "people associate together . . . because they think the relationship valuable as an end in, and of, itself" (1985, p. 27). In the context of health care this implies that local committees must become actively involved in planning and policy-making. Clearly there are both advantages and disadvantages associated with such an approach as has been shown above, but as Ikegami argues the penalty for not doing so "would appear to be letting the conflict of interests intensify in the quest for increasingly elusive resources" (1985, p. 42).

There is then a case to be made for giving the customer a greater say in planning and policy-making in the health sector. It would be unduly rash to suggest that the involvement of the public would transform, overnight, the long established and entrenched procedures for planning in the NHS, and yet, there is evidence available which suggests that customer involvement can produce benefits (Ham, 1980; Falk and Lee, 1978). The initial experience of the Partnership would

seem to substantiate the arguments of those who call for a greater role for the public, in whatever guise, in planning and policy-making in the NHS. Nevertheless, it must be borne in mind, that greater public participation is not without its impediments; it does take much longer for a consensus to emerge at a cost in resources, time, and personal sacrifice (Fagence, 1977). There is here then the makings of an organisational dilemma: whether the purpose of participation is merely to serve and ratify the interest of the organisation; or to enable the public to prepare with the relevant professionals plans and policies which would more closely reflect existing 'needs' and 'demands' for health care. The Newcastle experience suggests that the health authority, either intentionally or un-intentionally (it is not clear), tried to have it both ways, which culminated in fairly predictable results. And yet, one is left with a glimmer of hope that the tentative steps taken by the Partnership down the road to public participation may yet be repeated not only within the health authority but also elsewhere in the NHS.

CHAPTER TEN

CONCLUSION: LESSONS AND FUTURE DIRECTION

The ultimate objective of introducing a formalised planning process into the NHS was to ensure that the outcome of planning, in terms of services provided, would be commensurate with the 'needs' of the population. The health care planning team was considered to be the appropriate mechanism for achieving this objective. These planning teams were conceived as multidisciplinary groups, with members selected according to their professional skills and knowledge of health services. Furthermore, the role of the planning team was seen as advisory rather than executive - as a forum for discussion and formulation of plans and policies which were then forwarded to management for consideration and decision.

The research sought to accomplish two objectives: firstly, to determine to what extent the philosophy and rationale of health planning has become a guiding force leading to better policies; and secondly, to understand the factors which influence the planning process and the resulting policy decisions.

It is clear from the study and the available literature that the majority of planning teams have failed to live up to expectations. Although a number of factors have been advanced as contributing to loss of credibility in NHS planning, four issues appear to predominate. First, policy decision-making, rooted very much in incrementalist philosophy, has not given those who plan the services clear and succinct organisational objectives within which

to plan: planners generally do not know where they are going nor how they are going to get there. Second, since the philosophy of planning and its virtues have been given a low profile, planning has become a means unto itself, rather than, as was intended, the pursuit of well-chosen policy objectives. Third, the prescriptive nature of the planning system, with its emphasis on an annual timescale precludes any detailed or long-term analysis of problems to such an extent that most plans tend to adopt DHSS guidelines as de facto appropriate levels of service. Finally, in many cases satisfaction for most planners lies with the completed plan. Little or no attempt is made to evaluate the decisions arising out of the planning system in order to ascertain whether or not the original aims and objectives have been achieved.

This is the environment in which planning and policy-making has taken place in the NHS. From the evidence of the local case study, it has been suggested that, for the JPTE at least, these conditions prevailed. This was not true for the Partnership, and to some extent the JPTMH, although in the very early years it displayed some similarity with the JPTE. The distinguishing features which enabled the Partnership to progress were a committed leadership, lack of constraining services or facilities, relatively little conflict between planners and the caring professions on the type of service required, a sense of urgency that something must be done, and willingness to devolve responsibility for management to a body which accorded an equal say to patients and/or their representatives.

The study has demonstrated that the introduction of a formal planning system into an organisation, however well-intended, is of itself not enough without additional and continuing support. Designating someone a planner does not automatically mean that planning will result. In the local case study, mechanisms and procedures for planning were established and were religiously adhered to, and yet very little in the way of acceptable and implementable plans were produced. Any system, however well-designed, is only as good as the people working within it. This was clealy shown by the JPTE where the main protagonists, particularly those in the chair, acted more as gatekeepers rather than facilitators. As has been indicated, the gatekeeping role was manifest through the restriction or filtering of discussion items away from potentially sensitive local issues to a consideration of national policy matters where there was an identified common adversary - the DHSS. The lesson here is quite clear: if people are to undertake a planning role they need to know firstly what is expected of them and, secondly, that as agents of change they require organisational and managerial support if they are to do the job properly.

Leadership has emerged from the study as being a crucial ingredient in any recipe for planning and policy-making. Clearly there are leaders and there are leaders. Making one head of a planning team does not guarantee success as the example of the JPTE has regrettably demonstrated. Being titular head of something does not automatically ensure leadership; it may help but other qualities are necessary. The qualities required for effective leadership are difficult to identify precisely from the study but certain attributes can be

discerned and these are: a strong will and belief in the cause; a charismatic personality; an understanding of the complexities of the task and the different perceptions and perspectives of the various actors involved; and, a personal commitment that change is not only necessary but desirable. These people bring to the planning and policy-making process an enthusiasm for a new idea or change, a commitment to keep that issue on the agenda, almost at any cost, and they are prepared to actively promote its acceptance and introduction even if it means, as with the Partnership, placing one's organisational credibility on the line.

Power is another dominant issue which the study has documented and it is a factor which has been applied, almost but not exclusively, in a negative way. By far the biggest exploiters of negative power have been the medical profession who have used their position, status and prestige in the health sector to block changes with which they did not approve. This does not imply that their use of power is as a veto only, for there is evidence to indicate that they could be formidable allies to a cause provided that they are assured or convinced that the benefits of change outweigh the risks to be taken. However, as Stocking notes "altruism may be mixed with a judgement that promoting . . . innovation will increase their status locally or perhaps in their professional peer group" (1985, p. 43). Whatever the reason, change cannot occur without someone undertaking the role and responsibilities of a 'prime mover', 'product champion', or 'policy broker'; a first and necessary step to successful planning and policy-making. Equally, of course, such a person or persons must have a credible power base within the organisation which they are prepared

to exploit in order to affect the change they believe is necessary.

Thus do both leadership and power contribute to successful planning and policy-making - a sort of politics of conviction - where particular persons or groups are prepared to take a calculated risk to generate change within the NHS. But however important leadership and power may be, they are only effective if they can succeed in carrying a large supporting cast. Support for change or innovation must be carried throughout the organisation and beyond as the success of the Partnership attests. There is then a third ingredient necessary for effective planning and policy-making; involvement, not only of others in the organisation but also of the public.

Public involvement in planning and decision-making does not guarantee success; indeed many critics within the NHS have argued that for the Health Service to open up the decision-making process to greater public contribution would stifle rather than encourage better policies. The success of the Partnership clearly has disproved the theory that public involvement equals policy paralysis. What the Partnership has shown is that by giving the public a say in planning and policy-making greater commitment can be generated and that this in turn releases a collective energy across the board towards making the policy work.

In Chapter Four a conceptual model of planning was outlined which suggested that there was a set procedure or sequence to be followed and that this procedure, albeit in modified form, was that which underpinned NHS planning. The study has demonstrated that the

conceptual model was only partially adhered to, and even then it was difficult to point categorically to any example and say that this equated with one step or stage or another. From this it could be argued, with some justification, that conceptual models while useful in helping one to understand the system, do very little in explaining how the process should function. This is because planning and policy-making occur in a political environment which can, and often does, push those given the responsibility for planning in a variety of different and often conflicting directions. Thus the political dimension of planning and policy-making could be likened to a maze whereby one may enter several cul-de-sacs before emerging at the other end with an agreed plan or policy.

The observed failure of NHS planning to rise to the expectations of its advocates can be attributed to the fact that it was originally perceived of and applied as an activity divorced from management. Certainly, many of those with managerial responsibilities also were involved in planning and policy-making but they tended to see management and planning as separate functions which has inevitably led to the apparent denigration of both (DHSS, 1980a; DHSS, 1983). The separation of planning and management, where planning was a highly prescriptive function, and where management tended to behave more as administrators in that they followed a rather unadventurous code of practice (Keeling, 1972), has resulted in disenchantment all around and a search for a more co-ordinated form of policy-making.

Evidence from the study has demonstrated the need for a more integrated style of planning, policy-making and management. The

Partnership, which had planning as well as management responsibilities, clearly has illustrated that a deliberate association between these activities can produce positive benefits. What is needed by the NHS is a procedure which accentuates and reinforces the linkages between planning and management, instead of highlighting, as the study has shown, their distinctiveness. Such a process would have to demonstrate that the discipline inherent in planning, especially that of long-range or strategic planning, would not be sacrificed in the interest of expedient or incremental decision-making. Strategic management would seem to offer just such a potential to make the linkage between planning and management because it uniquely combines the discipline inherent in a system with the flexibility necessary for the development and implementation of policies.

Strategic Management - an agent for change

Why strategic management? The concept embodies two separate but not mutually exclusive components: strategic vision and effective implementation, both of which have often been lacking in NHS planning. The first, strategic vision, refers to the climate necessary for strategic management; that is, the synthesis of the merits of NHS planning with the all-important local strategic outlook. It is this latter component, sometimes referred to as the 'vision of the firm', which has often been missing from planning and policy-making as the research has illustrated. Strategic vision is commonly regarded to be the corporate philosophy or statement of basic principles which governs the manner or direction in which an organisation seeks to develop. The purpose of a corporate philosophy is threefold:

i) to communicate to both employees and customers the central purpose which underpins, guides and motivate the organisation;

ii) to provide a framework which governs the relationship between the organisation, those who work in it, and the wider environment within which it operates; and

iii) to state in broad terms the objectives to which the firm aspires with regard to future development and performance (Hax and Majluf, 1984).

The second, effective implementation, implies in practical terms an analysis and evaluation of problems and options, and taking positive planning and managerial initiatives. As the study has shown, particularly from the experience of the JPTE, this is not something at which the NHS is especially good. The Partnership was much more effective as a planning and policy-making body but then it possessed some key ingredients, which the JPTE did not nor, on the evidence presented, was ever likely to achieve as it was constituted. The Partnership was able to proceed where the JPTE failed because of political support, committed leadership, and the ability to effect its own policy. This latter feature is very crucial indeed, and exemplifies the important and necessary bond between planning and management.

The thrust of strategic managment is implicit in the term - the emphasis is on change. And, although the stress is very much on what should occur in the future, it should be remarked that it is the steps taken today which dictate whether or not the future becomes a reality. The strategic management process therefore must be firmly grounded in

the realities of today but equally must have a clear vision of the future. Thus it has the capability to enhance in a more positive way than hitherto both managerial understanding and planning and policy-making in the NHS.

The specific objective of strategic management is "the development of corporate values, managerial capabilities, organisational responsibilities, and administrative systems which link strategic and operational decision-making at all heirarchical levels and across all . . . functional lines of authority" (Hax and Majluf, 1984, p. 72).

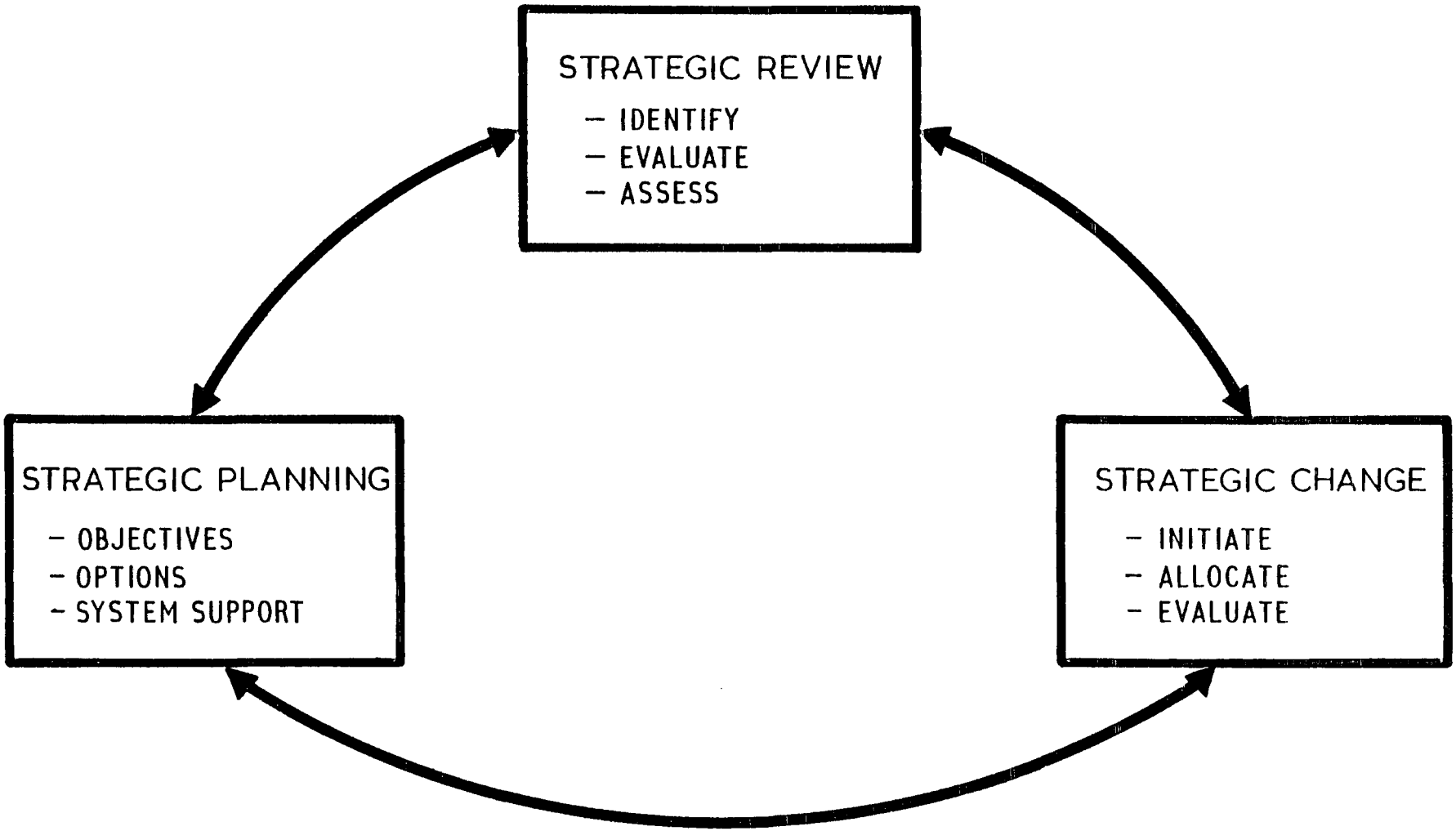
This description by Hax and Majluf is a useful starting point as it clearly identifies what strategic management seeks to do. What is not conveyed, however, is any sense of how it should and could be accomplished. To be fair, Hax and Majluf do offer a portfolio for strategic planning but one that is based entirely on commercial principles. Thus the techniques they discuss are those which operate well in a business or commercial environment but do not readily translate to a multifarious public sector organisation such as the NHS.

The concept of strategic management does commend itself but a different model to that of Hax and Majluf must be devised if the concept is to be of value to the health service. Such a model is described below; one which marries the key attributes of strategic change with the necessary understanding of the diverse nature and function of the NHS.

Strategic management as an activity contains three connected steps: strategic review; strategic planning; and, strategic change. Although the operation has three stages, in reality strategic management is a fluid process as figure 10.1 indicates. This means that although different levels can be distinguished, there is continual movement from one rung to another, backwards and forwards, as conditions and information change in light of the activities undertaken. However, for the sake of convenience each layer is considered seperately.

Strategic Review A three-part operation which begins with the identification of strategic problems, which, for instance, may centre around the longer term availability and utilisation of resources; the efficiency and effectiveness of existing services in the light of known or projected changes in demand; and, the manner in which resources and services are currently organised and the modifications which may be required in a continually changing environment. Once the strategic problems have been defined some consideration must be given to an evaluation of the environmental factors associated with the problems. These may be, for example, the likely influence on the health status of the community; the impact of social, political and technological change on resources, services, and/or the organisation; and the implications for inter-organisational relationships, arising from specific strategic problems. Describing strategic problems and evaluating the environmental factors implicit in them is insufficient without some assessment of the potential responsiveness of present policies and services. The sorts of questions which seem relevant are:

Figure 10.1. STRATEGIC MANAGEMENT - A FLUID PROCESS



a) whether or not current trends in service provision will be sufficient or adequate in response to the likely demand for and use of resources;

b) what is the life expectancy of existing capital assets, are they relevant to the changes proposed and of the appropriate quality; and,

c) will the projected revenue allocations satisfy the changes envisaged and if not what would be the likely consequences?

Strategic Planning It begins with an affirmation of the objectives to be pursued. An objective in this case is a statement of purpose or intent of a desired condition to be reached at some point in the future. This implies that choice must be made between the range of demands to be satisfied, and that the objectives so chosen should be clearly and concisely stated but not so precise as to be restrictive. The aim is for objectives that are easily understood and acceptable to the organisation and those who work and/or come in contact with it, and this can only be accomplished through the application of an agreed mechanism for determining priorities. It is also necessary and important to bear in mind the likely effects of choosing certain objectives over others as regards relationships within the organisation and linkages with outside bodies and agencies. The logistics and programming required to achieve this should be clearly articulated so that no misunderstandings arise to jeopardise the procedure.

The next step, once the objectives have been identified and delineated, is the generation of feasible, acceptable, alternative

means and the medium by which the policy or objective is put into practice. The feasibility of the alternative means must be judged and evaluated according to political, social, economic, and technical criteria which can only be determined in the light of local circumstances. Failure to undertake this assessment of the various means could well threaten the viability of the changes under consideration, and ultimately endanger the validity of the strategic planning process.

Deciding between objectives and generating feasible alternative means are of little value unless these activities are actively supported through the decision-making machinery. Such system support has many facets but there are some which are of particular importance. These can be stated as: the role of the planning manager; planning the planning; and analytical support. The role of the planning manager is crucial and because planning tasks and responsibilities are generally spread amongst several individuals it is important that each knows who does what, why and, if appropriate, how. Equally, the plan must be planned which means that there should be a document or procedure prepared which outlines the targets to be achieved in quantitative, qualitiative, and temporal terms. Analytical support refers to factual or base data necessary to sustain decision-making. This necessitates an established management information system and might include any additional material considered necessary which may be derived as appropriate from epidemiological studies, economic analaysis, operational research and so on.

Strategic Change The level at which the necessary climate for change is created and nurtured. There are three ingredients essential to facilitating strategic change. The first component is settling and instituting the strategy. In the preceding stages considerable stress was placed on ensuring that the overall aims, objectives and policies of the organisation were fully and widely understood - a crucial factor in the implementation of any strategy. Thus generating commitments is a sine qua non for strategic change. The conditions required for producing and sustaining commitment, according to Martin and Nicholls are:

> "a sense of belonging to the organisation, a sense of excitement in the job, and confidence in management leadership" (1985, p. 56).

Creating a shared understanding must also be coupled with more mundane activities such as a timetable indicating what requires doing and when, and identifying initial tasks.

The second constituent is gearing up the organisation in terms of allocating tasks and functions in accordance with the organisational structure. The structure also has an additional contribution in that individuals who assume responsibility for certain tasks and functions should be held accountable for any failure to carry out their activities as required. All this should be undertaken within a defined framework or modus operandi which clearly sets out the latitude and limitations associated with the allocated duties. The third and most crucial part of all is the continuing process of managing change. This requires good decisive management leadership at all levels of the organisation capable of motivating staff and

colleagues alike, a system of incentives which rewards success but does not punish failure caused by factors beyond the individual's or group's ability to master, and a set of control mechanisms which are fair, but firm. Freeman has termed this activity 'stakeholder management' because it

> " refers to the necessity for an organisation to manage the relationship with its specific stakeholder groups in an action-oriented way"

where stakeholders are defined as

> "any group or individual who can affect or is affected by the achievement of an organisation's purpose" (1985, p. 53)

Thus strategic change could be summarised as commitment and involvement.

Strategic management offers considerable potential as a change agent for the NHS. Unlike some other mechanisms, such as the formal planning system, it does not attempt to provide a prescription for tackling the strategic problems facing health authorities. The key ingredient of strategic management is the emphasis on integration, the marriage of the formal planning system with local strategic vision to produce policies, plans and programmes that are acceptable across the board. There is also a recognition that no matter how good are one's policies and plans, they are of little value if they cannot be implemented and therefore strategic management is also concerned with bargaining, negotiation and consultation and the need to develop positive managerial initiatives to affect policy change. In other words, an acknowledgement that consensus especially in the multi-

professional NHS is a crucial element in transforming policies from statements of intent into plans of action.

The management of today's health service is a difficult enough task without the additional consideration of how health care should and could be provided in the future. Managing change is never easy; the management of future change is especially problematical, not least in the difficulty of anticipating all future events. And yet the manager is continually having to cope with ever changing organisational, political, social, and economic environments. The endorsement and application of the concept of strategic management in the NHS should assist in the creation of health policies and plans capable of producing the desired future change.

There are many factors which impinge on the planning and policy-making process, some are understood but some are not; what is clear, however, is that the creation and implementation of a formal planning system and the introduction of planning teams to operate the system does not guarantee success as the research has shown. Structural changes are, at best, enabling mechanisms. It is only through a subtle blend of leadership, commitment, sacrifice, and common understanding on the part of planners, policy-makers and the public that planning will effect change in the NHS.

The essence of strategic management is sensitivity to what the organisation stands for, the individuals and groups working within it, and to the people it serves. Understanding the complexities of this

relationship is a pre-requisite for generating change. Strategic management provides a framework for constituting such understanding and builds upon this base to develop health care policies, plans, and programmes which ensure the commitment of both provider and receptor.

APPENDIX ONE

AN AIDE MEMOIRE FOR DISCUSSION

Interview Topics

1. As a member of a planning team how would you describe your contribution, within the team, to the formulation of policy and the development of those plans necessary to carry out that policy?
2. Consultation is considered to be an important attribute in planning, yet it has become rather discredited simply because it was not seen as providing the response which those in planning sought. What is your position regarding consultation? Who should be involved, and why, and at what stage in the planning cycle should they become involved?
3. Despite the best of intentions, planning teams do not often produce policies wholly acceptable to the health authority and consequently, the policies which are endorsed are generally prepared by the authority's planning staff. This observation appears to be supported in respect of the planning team for the elderly and less so for the mentally handicapped. What is your perception and if shared, what reasons can you suggest for this lack of congruence between plans and decision-making?
4. How would you describe your relationship with local authority/health authority members of the planning team?
5. The health authority and local authority, whilst sharing similar responsibilities for certain groups of people (e.g. the elderly, handicapped), often have very different views on the type of care required. Do you consider this to be an insurmountable obstacle to the development of joint programmes?

6. Some commentators suggest that there is reluctance by some members of the planning team to become actively involved in local issues, preferring instead to focus their attention to national policies and then the possible local impact of these policies. What is your opinion of this assessment?

7. It has been suggested that the existence of an established service or range of facilities for a specific client group is a distinct barrier to the development of innovative policies. Would you care to comment on the validity of this statement?

8. There are many factors, external and internal to the health sector, which influence the formulation of health policies. The various circulars and guidance from the DHSS and others suggest that multi-disciplinary planning teams are the most appropriate forum for coping with complex policy issues. What is your view on this?

9. Some commentators suggest that of the many groups involved in planning only two predominate - the medical profession and the adminstrator/planner. If this is so, why?

10. The role of the chairperson of the planning team is often seen as being crucial to the working of that team. This is because of influence over agenda items, understanding of the political environment, and the commitment brought to the position. How valid, in your view, is this assessment?

11. What should be the role, responsibility, and accountability of the Authority's planning staff?

12. Would you expect them to be passive supporters of the views of those providing care, or as advocates for a more wider debate, amongst all parties affected by the health services, on the problems facing the Authority?

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