From principles to practice

A commentary on health service planning and resource allocation in England from 1970 to 1980

MICHAEL BUTTS, DOREEN IRVING
CHRISTOPHER WHITT

Nuffield Provincial Hospitals Trust

Foreword

It will be evident to those who have read the periodical reports of the Trust and have been aware of the nature and scope of its publications that the Trustees have sought as a matter of general principle to use a combination of research projects, seminars and publications as a means of stimulating discussion of issues which are central to their policies concerned with the improvement of hospital and associated medical services.

The primary purpose of the Trust when it was founded was 'the co-ordination on a regional basis of hospital and ancillary medical services throughout the provinces' and among the earliest policies were the hospital surveys, the development of information bases and following the inception of the NHS in 1948, the setting up of the Investigation into the Function and Design of Hospitals, the report of which was published in 1955. All of these were concerned with planning health services in one way or another and the latter included the important final chapter 'Planning to Meet Demand', which sought to apply up-to-date statistical techniques to indicate the number of beds which ought to be planned in the particular catchment areas for which the major planning authorities, the Regional Hospital Boards, were responsible.

Since then planning has come more and more into the public eye with the Hospital Plan of 1962, and more recently with the introduction of the planning cycles following the 1974 reorganisation. It would seem from the collection of essays in this volume that it has hardly gone far enough in sophistication to meet the requirements of making the best use of resources.

At present planning in much of the western world, the UK included, is passing through a critical phase because it does not seem to rise to expectations. It was Disraeli who 100 years ago perhaps encapsulated the problem of planning in a free society when he wrote 'There are so many plans and so many schemes and so many reasons why there should be neither plans nor schemes'. The present Conservative Government is to introduce a simplified system of planning, the test of which is still to come, for modern society is of such complexity that effective planning, to be equitable and to make optimum use of resources is, however, unlikely ever to be simple.

Perhaps we should take heed of Einstein's words 'perfection of means and confusion of goals seem in my opinion to characterise our age'. It is hoped that this volume, with its attempt to relate the various problems against an historical background will be a contribution towards the goal of improvement in the general debate which continues.

G.McL.

Contents

Preface

We began collaborating on this study early in 1979. We were concerned about the health service planning and resource allocation exercises in which we had taken part as health service employees. So much surrounding those activities had seemed irrational. Effort was directed primarily towards implementing a system of planning to the detriment of a proper consideration of the methods by which plans would be formed. Questions about the relative feasibility, desirability, costs and benefits of alternative courses of action tended to be put aside. It was evident that there was a wide gulf between the principles laid down in official guidance from the DHSS and the practice within the NHS.

The management structure within health authorities made it difficult for effective collaboration on planning to take place between different disciplines, and plans tended to consist of a collection of unrelated contributions from individual officers. Some saw their contribution as little more than a routine form-filling exercise; others felt that a perfunctory response was inappropriate, yet there was little alternative with such tight deadlines, with limited knowledge and inadequate statistical information, and with a shortage of expertise and technical support. The opening up of NHS planning to wide consultation seemed to have little impact except to increase the volume of administrative work. Not surprisingly, plans lacked conviction and there was scepticism about their content.

Resource allocation was carried out as an exercise divorced from planning. Much effort was devoted to deriving and implementing formulae for determining financial allocations which were distinct from the process of service planning and used different criteria. Plans submitted by health authorities had little influence on their financial allocations. The translation of plans into operational budgets was a particularly opaque exercise.

We were also puzzled by the way in which decisions were taken within central government, and how these related to the planning and delivery of services within the NHS. The widespread cynicism within the health service about the central department - the Department of Health and Social Security - was matched paradoxically by an absence of much real knowledge about its structure and functions, and the way these influence its perspective and policies. In a wider context, an effective mechanism for coordinating the different policies of departments of state which relate to health appeared to be lacking.

In this book we attempt to unscramble the evidence of the last decade relating to these processes in order to point the way towards some improvement. We assess the principles upon which plan-

ning and resource allocation were founded and contrast these with the practice of what in fact happened when the processes were applied.

We begin in Part One by discussing the framework of parliamentary democracy and accountability within which the NHS functions. We consider the way in which fundamental principles such as ministerial responsibility and clinical freedom affect the development of health services. The public expenditure process, which sets the overall financial constraints for the NHS, is examined in relation to policies on financial distribution and to how money is in fact spent. We describe the administrative structure of the DHSS and its relationship with health authorities, and we examine its planning mechanisms.

The last decade has seen a major structural reorganisation of the NHS which was intended to improve management and to enable the introduction of a planning system. In Part Two, we trace the way in which the planning system evolved from ministerial principles, through official promulgations, to actual working practice. Against the backcloth of national policies on the balance and development of health care services, Regional Health Authorities have constructed plans for the next decade. We examine the basis upon which these plans have been founded and comment upon the different approaches which Regions have employed. We examine the features of the plans of the Thames Regions in some detail since to a large extent the achievement of national policies was contingent upon the successful resolution of the problems of London.

The introduction of the cash limits system, and a policy to redistribute finance geographically, have given rise to important problems of financial management which have been highlighted at a time of economic stringency. In Part Three, we examine the national policies which have been developed and the way in which they have been adapted for implementation within the NHS. We describe the lack of reconciliation between policies on the distribution of finance and policies on the development of services, and comment on financial management in the context of general service planning.

The next decade also promises significant changes in the way in which decisions are taken on the provision of health services. In the concluding chapter, we consider recent Government policies in the light of our examination of the practice of planning and resource allocation over the last decade. We comment upon the extent to which past failings might be remedied by the current bout of administrative reorganisation, and discuss those fundamental issues which remain to be resolved.

Part One was written by Doreen Irving, Part Two by Michael Butts and Part Three by Christopher Whitt. We are grateful to officials in the DHSS and the NHS who allowed us to interview them. We would like to thank also the following for their comments on earlier versions of the text: Professor Brian Abel-Smith, Professor John Ashford, Howard Glennerster, Dr. David Hunter, Nancy Korman, and Valerie Little. However, the responsibility for interpreting the evidence rests solely with us.

PART I

THE POLITICAL SETTING

1. Parliamentary democracy and accountability

When the National Health Service was established in 1948 the ownership of local authority and voluntary hospitals was transferred to the State. Aneurin Bevan, the Minister of Health, refused to leave the hospital authorities independent. His view was that 'the most sensitive instrument in this country for bringing about effective administration is the Question on the Order Paper of the House of Commons' (1). The present Secretary of State for Social Services has direct responsibility for the NHS as a result of Bevan's insistence on full accountability to Parliament. This political setting has had a considerable effect on the administration of the NHS. It influences policies and plans for health services, and the development of the planning process itself. Some of the difficulties which arise in the relationship between the NHS and the Department of Health and Social Security are a reflection of the operation of the principle of ministerial responsibility, a principle which Mackintosh describes as 'such a comfort to both officials and ministers' (2).

The Secretary of State for Social Services

As a member of the Cabinet, the Secretary of State for Social Services takes part in policy-making at the highest level of government. Except on major issues where the support of his Cabinet colleagues needs to be secured, he relies on his own judgement in deciding which policies the DHSS should pursue. The convention of ministerial responsibility assumes that everything his civil servants do is in accordance with the Minister's wishes, and that unless he takes an initiative or gives his approval, policies within the Department cannot be changed. Secrecy in government makes it difficult to assess how far this principle is respected in practice (3).

The Secretary of State is responsible for two other major services apart from the NHS. First there are the personal social services provided by local government, and second there is the entire system of cash benefits paid through the social security network, directly administered by the DHSS without the use of a statutory agency like the health authorities for the NHS, or the local authorities for the personal social services. In addition there are some centrally administered services, for example, the special hospitals at Broadmoor, Rampton and Moss Side.

The responsibility for health services is more extensive than for social services run by local authorities. By virtue of their status as elected bodies, raising funds through rates, local

authorities are recognised by Parliament to have a degree of autonomy which health authorities do not. In practice, this enables the Secretary of State to deflect some questions about personal social services by declaring that they are matters for the local authorities. He cannot employ the same tactic to fend off criticism of health services because he is ultimately responsible for them in their entirety, apart from clinical decisions.

It is evident from the scope of the work of the DHSS that the Secretary of State cannot possibly know in much detail what officials do in his name, yet he alone is responsible to Parliament. Furthermore, he is answerable for the NHS in just the same way as if it were directly administered by his civil servants. As recently as December 1979 - in the consultative paper Patients First (4) - the Government asserted that the Secretary of State must keep his statutory responsibility for the NHS.

One of the major functions of the DHSS is to help the Secretary of State play his role in Parliament by preparing draft answers to MPs' questions and briefing the Secretary of State or his junior ministers before they take part in debates, or attend committees or other meetings. There is also a large amount of correspondence to be dealt with that comes from individuals and groups outside Parliament. In his evidence to the Regional Chairmen's Enquiry in 1976, the Minister of State for Health said that he answered personally up to about 1,600 enquiries a month from MPs and members of the public (5). If it were not for the convention of ministerial responsibility much of the work concerning the NHS could be dealt with by the Regional Health Authorities, without involving either the Ministers or the Department. This would reduce the work of the DHSS but would not necessarily increase the work of the health authorities to the same extent, because they already supply much of the information which the DHSS passes on in response to enquiries.

It was the publication in July 1979 of the report of the Royal Commission on the NHS that provoked the Government to confirm its support of the convention of ministerial responsibility. The Royal Commission had recommended that 'formal responsibility, including accountability to Parliament, for the delivery of services should be transferred to RHAs' (6). The Government rejected this as 'inconsistent with the statutory responsibility and accountability to Parliament which the Secretary of State must retain' (7).

The need for accountability to Parliament arises from the way the NHS is financed, almost exclusively by funds voted by Parliament. In the last financial year (1979-80) expenditure on the NHS was estimated to be about £7.5 thousand million. Over 97% of this money was voted by Parliament, the remainder came from prescription and other charges (8). It has been claimed, however, that Parliament's control of the purse strings is 'a constitutional joke' (9) because party discipline ensures that the Government always get the funds it asks for (10).

If the Government had made Regional Health Authorities accountable to Parliament, it would have been through the Public Accounts Committee and the new Select Committee on Social Services that the NHS would have been scrutinised, with RHA representatives attending instead of DHSS officials. Obviously the RHAs could not have taken over the role of the Secretary of State in answering

MPs' questions on the floor of the House. A similar problem has been resolved in the case of the nationalised industries, where the ministers concerned are answerable to Parliament only on questions of general policy and not on questions of day to day administration.

The Government's rejection of the Royal Commission's recommendation seems to have been based not so much on practical considerations as political ones. First, Parliament would not have tolerated the change because the NHS is almost completely dependent on the annual supply vote for its income, unlike the nationalised industries which get most of their funds from trade. Second, there is no evidence of widespread support for the devolution of responsibility (and power) to the Regional Health Authorities and, in any case, the strengthening of RHAs would conflict with the Government's intention that District Health Authorities would have 'the minimum of interference' from above (11). Third, the Government knows that political responsibility means more than accountability to Parliament. Birch points out that responsibility can also be interpreted as responsiveness to public opinions and demands or as strong and consistent leadership. He argues that if these three kinds of responsibility had to be placed in order of priority 'the British political tradition would clearly determine the order as: first, consistency, prudence and leadership; second, accountability to Parliament and the electorate; and third, responsiveness to public opinions and demands' (12).

When the NHS was established, the Government conceded clinical autonomy to the medical profession, thereby accepting a limit on ministerial power and responsibility. Aneurin Bevan's words were:

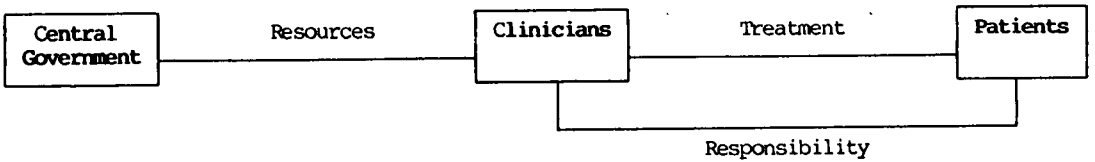
> I conceive it the function of the Ministry of Health to provide the medical profession with the best and most modern apparatus of medicine and to enable them freely to use it, in accordance with their training, for the benefit of the people of the country. Every doctor must be free to use that apparatus without interference from secular organisations. (13)

In effect, the Ministry of Health allowed doctors virtually a free hand in running and developing services. It gradually became clear, however, that the uneven geographical distribution of health services that had existed before 1948 was persisting. Hospital costs were increasing. Furthermore, the standards of care in long stay hospitals began to give rise to concern. Pressures also began to mount to integrate hospital and non-institutional care.

The 1974 reorganisation of the NHS created the opportunity for the Ministry of Health (now under the DHSS) to pursue more vigorous policies designed to rectify the problems that had been identified, namely, regional inequalities, deficiencies in non-acute hospital services, and lack of coordination between hospital and other related services. A planning system was introduced to promote these changes. Health authorities began to find themselves pulled in opposing directions, trying to satisfy the priorities of the Department at the centre and meet the requirements of those in contact with patients at the periphery (see figures 1 and 2).

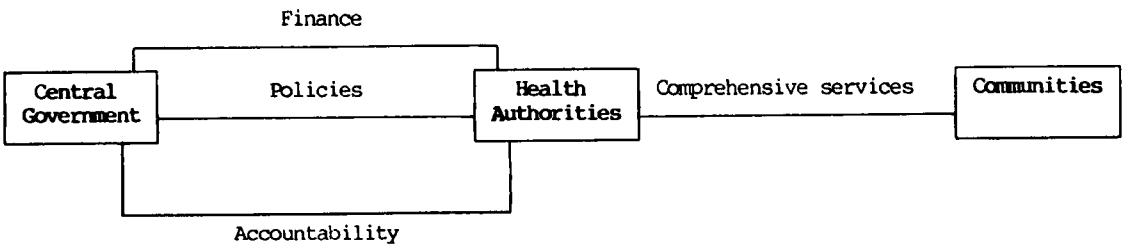
It has been argued that planning is used to control the exposure of conflicting forces in society (14). The NHS planning system has

a) Simple clinical model



Central government gives resources to clinicians. Clinicians treat patients and are responsible to them.

b) Simple administrative model



Health authorities provide a comprehensive service to geographically defined communities. They are accountable to central government which supplies finance and indicates policies to be followed.

Figure 1. Clinical and administrative perspectives

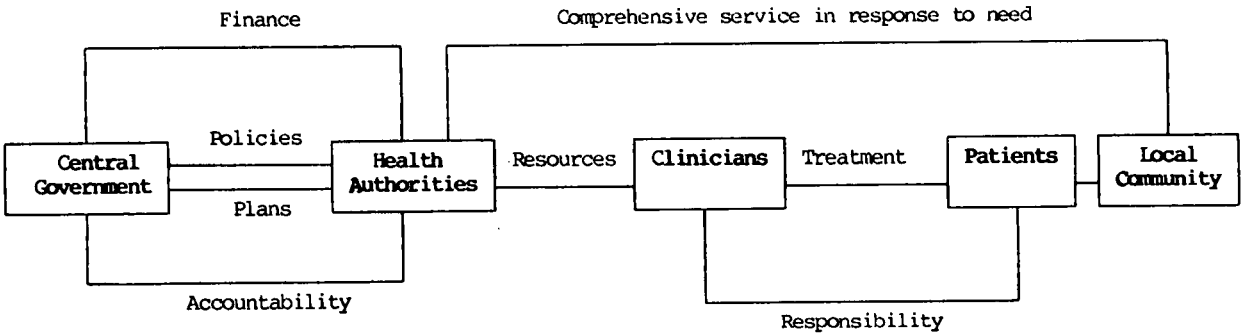


Figure 2. The dilemma which planning seeks to resolve: How to reconcile central policies with clinical freedom and local interests

provided an arena for local community and patient interests to engage in unequal combat with both medical and government interests. The rules of the game, its duration and its various stages, have been laid down in official guidelines, and the insistence of central government that Regional Health Authorities should submit plans by a particular date has ensured that some action would take place. The managerial philosophy underlying the NHS planning system has tended to obscure the intense political activity which is provoked by the prospect of changes in the distribution of resources. Instructions about planning issued to health authorities by the DHSS take for granted a public acceptance that power is concentrated in central government, and that national and local interests can be harmonised through the management arrangements of the reorganised NHS. There has also been an assumption that the hierarchical design of the NHS allows for some decentralisation of decision-making, that the planning system allows 'real delegation downwards, accompanied by accountability upwards' (15).

How does the NHS planning system fit into the broader context of government planning? If the system of parliamentary voting of funds to the Government is something of a formality, how is the NHS share of public expenditure determined? Given that the supply of funds is granted for only one year at a time, how much uncertainty is there about future allocations? What is the status of the public expenditure plans which are published as White Papers annually by the Government? It will be easier to discuss these questions if we first take a look at central government as a whole.

Central Government

In the years following the Second World War the range of activities of government has increased. The establishment of the NHS in 1948 is just one example. The growth of intervention has been accompanied by a rise in public expenditure and an increase in the number of civil servants. One effect of this expansion of government has been to alter the balance of power between Parliament, Ministers and the Civil Service. Among politicians, the strength of the Government, especially the Prime Minister and the Cabinet, has increased. Backbench MPs and the Opposition know that, in effect, they are up against not only individual Ministers but also the whole complex machinery of Whitehall. Within Whitehall, that is when the Government is taken to include Ministers and the Civil Service, the extended scope of government intervention and the increased number of civil servants have restricted the extent to which a Minister can know what his officials are doing. Rose has argued that the characteristic spirit of Whitehall is set by civil servants, because they are more durable than Ministers as well as more numerous (16).

The Civil Service 'is moulded chiefly by the doctrine of ministerial responsibility with all that flows from it - anonymity, one collective viewpoint, secrecy and a degree of isolation from the rest of the community' (17). For civil servants, anonymity is a protection; for Ministers, secrecy ensures that they are better briefed than their critics. In a recent interview

the Secretary of State for the Environment described his relationship with civil servants in these terms:

> It's impossible to move very far without becoming involved in a discussion with your civil servants. They after all have the day-to-day responsibility for carrying out the ministerial wishes. So you spend a lot of time with them, and it's an immensely stimulating relationship. There can be no doubt that compared to any other form of activity I find the quality of intellectual dialogue around a particular subject within the Civil Service briefing to be without equal. (18).

The work of top permanent officials is mainly concerned with political management, oiling the Whitehall machinery by briefing Ministers and keeping in touch with developments in other parts of Whitehall. The routine administration of public services is left to lesser officials and a variety of agencies, among which the nationalised industries and the health and local authorities are the most prominent.

One feature of the strong leadership of central government is what Birch calls the tradition of discretion: 'that developments in Whitehall need not be divulged to any outside body except Parliament, and even Parliament's rights to information are closely restricted by convention'. An aspect of this tradition is 'the general agreement that it is better not to probe too deeply when things go wrong' (19). The record in the Crossman Diaries of the scandal about Ely Hospital provides an illustration of the way in which the ability of civil servants to conceal what they know, leads to the creation of a vacuum of management at the top of the National Health Service, through the failure of the DHSS to act on the information it receives.

> Wednesday, March 12th (1969)
> At 12.30 this afternoon we had the critical meeting on Ely in my room at Alexander Fleming House with about twelve people round the table. Bea Serota came ... One of the most dramatic moments of this meeting was when I referred to our not knowing anything about it and Bea said, 'Didn't we? You ask the Chief Nurse what she knows about it.' Dame Kathleen said, 'Oh, yes. We used to have people going down there, regularly visiting'. I said, 'Did they report?' 'Yes'. 'When was the last report?' 'Three or four years ago.' 'Have you got it?' Bea had arranged to have it and she threw it across the table at me. It was a deplorable report, admitting scandalous conditions, bad nursing, the basis of all the News of the World revelations that Geoffrey Howe had confirmed. I asked what had happened to this when it came in and the answer was that it had gone on file (20).

Select Committees of Parliament

There have been several attempts at parliamentary reform designed to restore the lost influence of the House of Commons. The most recent innovation has been to redesign the select committee struc-

ture following a report from the Select Committee on Procedure in session 1977-78. The essence of the problem is stated in the report to be 'that the balance of advantage between Parliament and Government in the day to day working of the Constitution is now weighted in favour of the Government to a degree which arouses widespread anxiety and is inimical to the proper working of our parliamentary democracy' (21). The select committees were formed only recently (during the 1979-80 session); it is too soon to judge whether they will be more effective than the committees they replace.

The importance of select committees is the role they play in the process of accountability to Parliament. When the business of government was more limited, the questioning and debates that occurred in the House of Commons were enough to satisfy the principle that Ministers should be answerable for the actions of public servants. 'In every free state, for every public act, some one must be responsible; and the question is, who shall it be? The British Constitution answers: "the minister, and the minister exclusively"' - that is how Gladstone saw it a hundred years ago (22). Even then, the process of scrutiny by MPs had begun to include the questioning of officials, through the Committee of Public Accounts which was established in 1861. This committee has been re-appointed annually and has survived the recent changes in the select committee system.

Richard Crossman, when he was leader of the House of Commons, set up the forerunners of present departmental select committees. In December 1966, he announced that two committees would be set up on an experimental basis. What was particularly important about those committees was that they were given power to examine witnesses and hear evidence in public. Previously, select committees had always met in private. The next major step towards the present system was when the Select Committee on Public Expenditure was set up in 1970. It had wider powers than the Estimates Committee which it had replaced, in that it could consider policy as well as administration. The principle that select committees could ask Ministers to give evidence also came to be accepted during the experimental period in the late 1960s (23). The Expenditure Committee and its sub-committees were empowered to send for 'persons, papers and records'. This enabled them to summon Ministers, and other witnesses as well as civil servants, and to ask Departments to submit memoranda. The reports of the Expenditure Committee have provided useful information about the workings of central government, which we have drawn on particularly in relation to the DHSS.

Birch's argument that Whitehall does its best to limit even Parliament's rights to information is supported by a document prepared by the Civil Service Department as guidance for officials appearing before select committees. General Notice GEN 76/78, which was issued in 1976 with ministerial approval, and later published in the First Report of the Select Committee on Procedure in 1977-78 (24), states that:

> The general principle to be followed is that it is the duty of officials to be as helpful as possible to Committees, and that any withholding of information should be limited to

> reservations that are necessary in the interests of good Government or to safeguard national security.

It is evident that civil servants (backed by Ministers) are to be the judges of what is in the interest of good government, not MPs:

> The fact that a report is known to have been prepared does not of itself oblige a Department to reveal its contents and inasmuch as the report may be the confidential property of the government, it is entirely within the power of the government to decide whether its contents should be published or otherwise made available to Select Committees.

The opportunity is taken to warn officials that they may need to be even more on their guard in the future:

> While Select Committees should not press for internal advice to Ministers to be revealed, they are less likely to accept without argument a refusal to reveal a report from a departmental Committee containing outside members, and even less likely to accept a refusal in the case of a wholly external Committee. In particular, they will be understandably reluctant to accept a refusal where the establishment of the Committee in question has been announced, together with its membership and terms of reference, and where its report is known to exist. These implications need to be taken into account in deciding how much publicity should be given to the establishment of Committees of this kind.

The helpfulness that officials are to show to select committees seems to be largely a matter of drawing their attention to material already in circulation:

> Requests for documents which go beyond a description of the existing organisation of the Department and deal with methods of operation (eg. arrangements for formal and informal co-ordination; for delegation of authority) or with reviews of existing Departmental organisation or methods raise more difficult questions. There may be some documents in these categories which could appropriately be given to a Select Committee. For example, reports on the outcome of management reviews may in their final form be semi-public as a result of having been made available to the Departmental Staff Side or to Departmental staff generally. (authors' emphasis)

A revised version of this memorandum was issued in May 1980 which had only minor changes, e.g. the words emphasised above were dropped, presumably because they were so revealing of how little the Government was prepared to concede to Parliament. Given this attitude towards select committees it is not surprising that a study of the impact of the Expenditure Committee led to the conclusion that the power relationships between Parliament and the Government had remained essentially unchanged (25).

Among the reforms suggested by the Procedure Committee in 1977-78 was that select committees should not merely have the power to

send for persons, papers and records, but also to order the attendance of Ministers to give evidence to them, and to order the production of papers and records by Ministers. Even if this power were granted, it would not solve the initial problem, which is to know what documents exist in Whitehall's files, and to have an idea of what is going on so that pertinent questions can be asked.

The select committees have been given few resources to help them in their work. For example, the present Social Services Committee clerk is a retired civil servant who now works part-time. The Guardian (26) quotes a remark by an unnamed source about the committee clerks:

> The least you might say about some of them is that they are the absolute opposite of the sort of person you might find as assistants to the congressional committees in the United States. The latter tend to be young, dynamic lawyers with political ambitions who can actually take a lead in negotiations with departments.

The committees are able to appoint specialist advisers who can brief committee members before they hear evidence and prompt them by passing notes while witnesses are being examined. Advisers cannot question witnesses directly.

Committees have varied in their choice of what to investigate. Some have gone for controversial issues like overseas student fees. Others have chosen long-standing problems, like the subject of perinatal mortality, investigated by the Social Services Committee. The Treasury and Civil Service Committee is the most influential. It has taken over from the (now defunct) Expenditure Committee the task of examining the annual Expenditure White Papers, and has already tackled many other important issues.

The select committees expect the Government to publish a response to their reports, but they have to be persistent if they want to see their recommendations acted upon. The Chairman of the Environment Committee is reported to be 'anxious not to arouse expectations that could not be fulfilled'. At a seminar of the Royal Institute of Public Administration he said that backbench MPs who sit on select committees had often, in the past, been labelled as 'uninformed cranks'. If the new select committees did no more than turn them into 'informed cranks' then the exercise would have been 'worth while' (27).

Whitehall

The Department of Health and Social Security is one of the main spending departments. From the table of public expenditure programmes (Table 1), the other major spenders are the Department of Education and Science, the Ministry of Defence, the Department of the Environment, the Departments of Industry, Energy, Trade and Employment, and the Home Office. In many cases the spending is done mainly by local authorities or other agencies, rather than by the central department itself.

During most of the 1970s the ministerial heads of these departments were in the Cabinet along with other senior Ministers, such

Table 1
Estimated Public Expenditure in 1979-80 by Programme

	£ thousand million at 1979 survey prices
Social security	19
Education and science, arts and libraries	10
Health and personal social services	9
Defence	8
Housing	5
Roads and transport	3
Other environmental services	3
Industry, energy, trade and employment	3
Law, order and protective services	2
Northern Ireland	2
Government lending to nationalised industries	2
Overseas aid and other overseas services	2
Agriculture, fisheries, food and forestry	1
Common services	1
Other public services	1
Total Programmes	71

Source: The Government's Expenditure Plans 1980/81 to 1983/84 Cmnd. 7841

as the Chancellor of the Exchequer. The Treasury itself is not considered to be a major spending department. Its role is that of an intermediary between Parliament and Whitehall. All funds voted by Parliament for the various ministries are channelled through the Treasury, and each year the spending departments have to seek Treasury approval for their forward estimates of public expenditure. The Treasury has sections which are organised to match the various departments, keeping a watch on their expenditure and going over their estimates. The convention of ministerial responsibility tends to strengthen the vertical organisation within the departments and to weaken the effectiveness of liaison with other departments, although inter-departmental committees are not at all rare in Whitehall. Compared with the spending departments themselves, the Treasury is in a good position to co-ordinate the departments, though its style of working is geared to controlling rather than co-ordinating.

Co-ordination

The co-ordination of policy between Departments of State is of crucial importance for the NHS because health care goes beyond the narrowly defined areas of responsibility of public agencies. Apart from family care and self medication, the availability of alternatives, whether in the private, voluntary or public sector, has a significant effect on the services which need to be provided

within the NHS. Sheltered housing for the elderly, education services for mentally handicapped children, employment policies affecting the disabled, are examples of services outside the NHS (and the DHSS) which influence the balance of services required within the NHS. If the scope is widened to consider the prevention of ill-health, then environmental factors are of major importance, although these are largely outside the control of the DHSS.

The Cabinet can and often does co-ordinate policies. So do inter-departmental committees of officials. The Chief Medical Officer of the DHSS acts as medical adviser to other Whitehall departments. This helps promote a unified view of health policy. It might be expected that high level inter-departmental discussions of subjects like health would engender a co-operative attitude among the relevant statutory agencies, but this does not seem to happen in practice. Lines of demarcation tend not to be crossed. The mechanisms for securing co-ordination in the provision of services are weak.

There have been attempts in Whitehall to create a framework for looking at social policy as a whole. The work of the Central Policy Review Staff is a prominent example, though this may be only because it published its thinking (28). Unfortunately there is little evidence that initiatives such as the CPRS's joint approach to social policies have had much impact. On the other hand the practice of shadowing Cabinet committees by committees of civil servants from the relevant departments does ensure that consultation occurs across departmental boundaries. In the face of the Whitehall tradition of strong functional departments, the responsibility for developing coherent social policies rests firmly with the Cabinet and the Cabinet Office, which provides the secretariat for committees. The Cabinet Office also contains the Central Policy Review Staff and the Central Statistical Office, whose annual publication of Social Trends is another sign of an inter-departmental perspective on social policy (29).

Mackintosh suggests that the 'Cabinet Office seems to have superseded the Treasury as the main co-ordinating office' (30). This is supported by Sedgemore's claim about the change that took place between the 1960s when he was a civil servant (1962-7), and the 1970s when he was an MP (1974-9) and Parliamentary Private Secretary at the Department of Energy (1977-8):

> The effectiveness of inter-departmental committees had grown enormously. In particular the inter-departmental civil service committees which now parallel each Cabinet sub-committee were exercising great power (31).

This change points to greater adherence to the principle of collective responsibility. The situation is fluid because 'just as individual responsibility operates where and when the Prime Minister and the majority of the Cabinet want it to operate, collective responsibility can be applied or waived depending on the convenience of these same politicians' (32). The point to note is that this is the setting in which crucial decisions are made affecting the NHS, although almost completely hidden behind the screen of official secrecy. The DHSS officials in contact with the health authorities know more than the NHS about this activity, and

take a great interest in it, but individuals near the bottom of the administrative hierarchy (such as the Regional Principals who act as the communication link between the NHS and DHSS) are not kept well informed about what is happening at the top, especially if it is not obvious that they need to know a particular fact or decision.

Inter-departmental committees have succeeded in improving the flow of information at the higher levels. Below these, communication throughout and between hierarchies narrows rapidly. NHS officials often despair of getting the information they want from the DHSS, and vice versa. Introducing a planning system into the NHS exposed some of the problems of communication which afflict all bureaucracies, especially when innovation is occurring.

Public Expenditure Survey Committee

The focal point of government planning is the Public Expenditure Survey Committee which is an inter-departmental committee chaired by the Treasury. This committee was set up following the Plowden Report on the Control of Public Expenditure in 1961. A view of the Cabinet Committee and its official counterpart is given in the Crossman Diaries.

> Monday, July 18th 1966
> The PESC meeting has become our regular July exercise. Its job is to keep the growth of public-sector expenditure in line with the growth of the economy. This year it had been found that although the rate of economic growth had declined, the growth of Government expenditure had jumped .... therefore there had to be something of a cut-back. What was clear to me was that it was useless to attempt this regular annual cut-back until we had seen the crisis measures which were being prepared behind our backs. It took most of my colleagues a full hour before they grasped that official Whitehall was busy quietly working out a precise package of cuts for announcement on Wednesday while we as Ministers were sitting round the table blithely discussing the remote possibility of retrenchment (33).

Three years later, when he was Secretary of State for Social Services, Richard Crossman tried to introduce a motorist's levy to cover the cost of road traffic accidents 'and the only way I made the thing acceptable at all was by saying that otherwise the £9 million would have to be raised by the cut in hospital building and it's now too late to do that without bringing the whole of this year's programme to a stop. It shows you how completely this awful PESC dominates proceedings and decisions' (34).

Before 1969, the PESC process had resulted in occasional White Papers. From 1969 onwards, Public Expenditure White Papers have been published annually. A handbook produced by the Treasury gives the timetable for the survey as follows:

> **December:** Instructions on the conduct of the coming year's Survey are issued by the Treasury.

End-February: Departments responsible for blocks of expenditure send returns to the Treasury including their up-to-date estimates of the cost of existing policies for the coming five years.

March-April: The Treasury and the individual spending Departments discuss these estimates, and the supporting information provided by the Departments, in order to reach agreement on the policy and statistical assumptions on which the estimates should be based, and then on the figures themselves.

May: A draft report on public expenditure is drawn up by the Treasury, and agreed in the Public Expenditure Survey Committee.

June: A report is submitted to Ministers.

July-November: Ministerial decisions are taken on the aggregate of public expenditure and its allocation to the various programmes.

November-December: Publication of the programme estimates embodying these decisions in the annual public expenditure White Paper (35).

The timetable may vary and often has. For example, the publication of the most recent plans was delayed until Budget Day in March 1980. The timetable above shows that when the Conservative Government was elected in May 1979 the PESC process should have been half way through its annual cycle. Any work that had been done on continuing the policies of the 1974-9 Labour Government would have had to be changed extensively to reflect the new administration's priorities, including its commitment to cut public expenditure.

The DHSS and other spending departments have developed systems of programme budgeting to assess the expenditure implications of various options or assumptions about government policies (36). Curiously, the policy assumptions agreed with the Treasury for the PESC exercise will not necessarily be linked directly to departmental policies. For example, there is no evidence that any allowance has ever been made by PESC for the cost of implementing the recommendations of the Resource Allocation Working Party (37), although there would be substantial costs in bringing about movements of capital and manpower between and within Regions. The policy is acknowledged, but the cost of implementation is not.

Bevan's experience as Minister of Health in the late 1940s shows that the problem is not new:

> Added to the normal hostility between a great spending department and the Chancellor went Bevan's growing suspicion of Treasury planning. Book-keeping records of the capital investment programme, indeed the convention of annual Budgets, gave the Treasury planners the idea that when they moved figures from one column to another physical resources could be adjusted as easily (38).

Although this comment was made in relation to the housing programme, then the responsibility of the Health Minister, a similar comment could have been made in the late 1970s about the unacknowledged costs of changing the pattern of health services, not only geographically but also to bring the non-acute services up to a satisfactory standard. For instance, the most recent Expenditure White Paper states that:

> Over the period to 1982-83 the planned expenditure allows for demographic growth (about 0.7 percent a year on average) and leaves a small margin for the spread of improved medical techniques and other improvements in health care. The process of resource reallocation will continue. In England national priorities for the use of resources will be reviewed in the light of regional strategic plans (39).

Note that allowance is made for demographic growth, improved medical techniques and other improvements in health care. No allowance is made for implementing the policy of resource reallocation. It is unclear what is covered by the phrase 'other improvements in health care' but it does not seem to be related to the priorities mentioned a couple of sentences afterwards. It is taken for granted that the health authorities can absorb the costs of implementing DHSS policies and that no additional costs are entailed in changing, as opposed simply to maintaining, the pattern of services. The connexion between PESC and the Department's policies is obscure.

The National Health Service has become familiar with programme budgets, which underpin PESC calculations, through their appearance in planning guidelines and strategy documents, such as the 1976 consultative document Priorities for Health and Personal Social Services in England (40) and The Way Forward (41) in 1977. The traditional system of keeping accounts by institutions does not yield direct answers to questions such as: how much is being spent on the care of the elderly? The technique of programme budgeting is designed to manipulate financial and other information in such a way that policy options can be costed in a crude but scientific way. The scientific aspect comes from the methods being systematic, making explicit assumptions and being open to improvement by public criticism (42). The crudeness of the calculations comes from the sweeping assumptions that need to be made before the data will yield answers to questions in the form posed by policy makers.

One of the reasons why the DHSS has decided to develop a system of programme budgeting was 'that other departments might be able to use the new output budget technique to establish their cases for more expenditure more effectively, in the annual round of PESC negotiations, than the DHSS, if we could not produce similar information linking expenditure to services produced' (43). In this respect the programme budget calculations have been noticeably successful in gaining recognition of the pressure on the health and personal social services which will come from the increasing number of very elderly people (aged 75 years or more) in the population. The relationship between the programme budget and PESC has resulted in the familiar demarcation of boundaries.

'The programme budget covers all health and personal social services for England, as defined for the public expenditure survey, at national level. Some closely related expenditure is excluded because it does not fall within this description, for instance, sheltered housing, and sheltered employment and blind workers' schemes' (44). The link between health policies and finance is constrained by the bilateral nature of negotiations with the Treasury in the first half of the annual PESC cycle (see timetable above). Each department prepares its submission with a view to obtaining as much as it can. Both before and after the mid-year report to Cabinet the process tends to encourage competition rather than co-ordination between the spending Departments. Furthermore, within the Cabinet a Minister has a greater incentive to strengthen his own department than to take a wider view, which could result in other departments gaining at his expense.

An odd feature of the PESC system is that if a Minister is successful in arguing a case for more funds, there is no mechanism for ensuring that the funds are used for the exact purpose put forward in the argument, at least as far as the NHS is concerned. There are negative controls, such as sanctions on new senior posts, but central government often finds it difficult to make health authorities comply with instructions to do something positive, such as building secure premises for violent psychiatric patients. Once the annual allocation has been made, the health authorities are not penalised if they do not spend it in accordance with the Department's guidance. For instance, the extra funds designed to provide for larger numbers of very old people will not necessarily be channelled into the kind of services that old people need. Indeed the whole purpose of introducing a planning system into the NHS was to make the Department's supervision of developments in the service more effective (45).

The value for the NHS of the Public Expenditure White Papers is that they provide a loose framework for planning by showing the direction of the Government's thinking and the funds likely to be available. Future allocations are uncertain, in so far as Parliament votes funds for no further ahead than the coming year. Supplementary estimates for the current year may also be presented, although cash limits have been introduced to make this less likely. The economic forecasts on which the plans are based may prove to be wrong, and other circumstances (such as a change of Government) may cause the plans to be altered. Nevertheless, the publication of the Government's intentions does imply some commitment, even if a degree of uncertainty is inevitable.

Cash Limits

An important feature of the PESC system is that it focuses on real resources rather than finance. All the figures in the Public Expenditure White Papers are quoted at constant prices. Adjustments are made in the calculations to allow for the relative price effect, i.e. that some prices rise faster than others, but the spending plans are decided in terms of goods and services rather than the money needed to pay for them.

This approach ran into difficulties in the mid 1970s, when

inflation became a major problem. Cash limits were introduced in 1976 to put a stop to the practice of presenting Parliament with supplementary estimates throughout the year, which had cushioned the public sector from the effects of inflation. Since then, planning in volume terms over the coming four years has given way to short-term monetary control (46). The 1979 Conservative Government has a stronger commitment to monetary policy than the Labour Government, which adopted cash limits under pressure from the International Monetary Fund. The Conservative Chancellor of the Exchequer, Sir Geoffrey Howe, has stated that:

> The main objectives of the Government's economic strategy are to reduce inflation and to create conditions in which sustainable economic growth can be achieved (47).

Such a policy creates an unfavourable climate for the PESC system. It is no longer possible to plan as if inflation were a peripheral issue that could be taken care of by a technical adjustment in the calculations. Cash has taken over from real resources as the basis for planning in practice, thereby calling into question the validity of the PESC exercise.

Three Year Plans

The planning guidelines which the DHSS gives to health authorities are based on the outcome of the PESC process. The Government's spending plans extend over a shorter period than the ten years covered by NHS strategic plans. It had been the practice for the expenditure plans to look ahead four years, but the period has been shortened to three years for the next survey. When this was announced in May 1980, it was reported in The Times (48) that:

> The intention is to cut the length of time over which the Government makes any commitments of its spending intentions.

It was also reported that:

> Ministers have made it increasingly plain since taking office that they are sceptical of much of the detailed forward planning of public spending which goes on in Whitehall.

Two of the reasons given for reducing the period covered by the spending plans were: first, 'that the final year of present four-year plans is so remote as to make it difficult to have serious consideration'; and second, 'that relatively few capital projects involve large quantites of spending later than the fourth year'. Neither of these reasons has much validity for the NHS, where the size of capital projects and the slowness of change make four years a short time. Nevertheless, Patrick Jenkin is said by one of his officials to have instructed that NHS planning 'should be scaled down so that we have enough information for testing whether government policy is being followed'. This reduces planning to an information system, and gives no indication of what would happen if government policies were not being followed.

Central control and local freedom

There is a gap between theory and practice in the relationship between the NHS and central government. In theory, the Secretary of State has complete control over the NHS, except for clinical decisions. The health authorities are agencies with no formal independence, consequently the services they manage are not independent either. In practice, central government has very little power to change local health services (49).

The Secretary of State would like health authorities to respond to the Government's policies, but what can he do if they take no notice? The suspension of the Lambeth, Southwark and Lewisham Area Health Authority in 1979, after its repeated overspending and refusal to cut services, was an exceptional case. Total sacking, even if carried out within the law, is too strong a sanction to be used in normal circumstances. More usual methods are to send for the Chairman of a recalcitrant authority to insist that he carries out the Minister's instructions; also, to take the opportunity when health authority members and chairmen come up for reappointment to replace critics and protesters by more compliant people. Such occasions are rare. The DHSS attempts to control the NHS on behalf of the Secretary of State in a way that minimises friction. The Royal Commission on the National Health Service thought the relationship between the NHS and the DHSS was unsatisfactory. It reported problems in top management of the NHS and that:

> The establishment of an independent health commission or board to manage the NHS was one of the solutions most frequently advocated in evidence (50).

The Royal Commission considered four ways of reducing direct involvement of the DHSS in NHS matters:

> (a) transferring the NHS to local government;
> (b) establishing a health commission;
> (c) devolving power to health authorities; and
> (d) establishing an inspectorate.

It recommended the third option, although it did recognise that:

> a health commission might have the important advantage of providing the permanent and easily identifiable leadership which the service at present lacks. An NHS view would be presented publicly by a body representing the whole of the NHS and only the NHS. Planning and decisions on the use of resources would be seen to be carried out by an independent body (51).

The political skills which civil servants have developed are different from those associated with practical management. Mackintosh has argued that ministerial accountability to Parliament is the doctrine which shapes the Civil Service, but that the original point of the doctrine has disappeared (52). Now that the Government has gained control of Parliament, Ministers no longer feel obliged to resign over maladministration by their officials.

The series of scandals in psychiatric hospitals, for instance, has never led to a resignation. Indeed, it is almost thirty years since a Minister resigned because of parliamentary censure (53).

The Government's rejection of the recommendation to devolve power to health authorities re-opens the questions posed by the Royal Commission about the role of the DHSS, and possible alternative forms of top management for the NHS. Looking again at the options, it is inconceivable that the 1979 Conservative Government would want to transfer the NHS to local government. The extent of central funding for the NHS, the traditional resistance of local authorities to central control, and strong NHS opposition to a take-over, are some of the reasons why this option would not appeal to a government which is attempting to reduce local authorities' spending. Even if either of the remaining options were adopted, namely, the establishment of a health commission or an inspectorate, surveillance and interference by the DHSS would continue.

Irrespective of the Government's intention to increase local decision-making in the NHS, the convention of ministerial responsibility prevents the limiting of government activity to deciding major policies, and exercising broad control. There is no prospect of a significant change in the relationship between the DHSS and the NHS until the principle of ministerial responsibility has been undermined. Paradoxically, the abandonment of the principle would strengthen Parliament, for then it would 'be possible to end the pyramidical structure of the Civil Service, to diminish anonymity, to decrease secrecy and to open up the processes of public administration to public discussion and accountability. Also it is almost certainly the case, that in terms of pure efficiency, it does any administration good to have to explain and defend its policies against every variety of argument and pressure which interest groups and an informed representative assembly can bring to bear' (54).

Under the present system, the Government is limited not so much by the power of Parliament to oppose legislation and refuse funds but by an absence of mechanisms for implementing policies. The NHS planning system was intended to be such a mechanism.

2. The Department of Health and Social Security

At the end of 1975, Dr. David Owen invited the Chairmen of Regional Health Authorities at their suggestion to set up a small team to investigate the working of the Department of Health and Social Security. The offer was made at a meeting at which the need to reduce management costs was being discussed, and the Minister was seeking the co-operation of the Regional Chairmen to cut spending on administration. Very few people in the National Health service have more than a vague understanding of how the DHSS works, so it is not surprising that the Chairmen leapt at the opportunity to take a look round and comment on how the Department could help in achieving economies. Their enthusiasm can be seen from the speed with which they acted. The invitation was issued just a week before Christmas and yet the enquiry team of three Chairmen had already been selected and held its first meeting before the end of December. The investigation resulted in a critical report produced six months later, in May 1976. In his book In Sickness and In Health, Dr. Owen described his invitation - which he attributed to the 1974 Labour Government - as an unprecedented step 'so as to achieve an open dialogue' (1). The three Chairmen shared this view:

> We believe that it is unique for an organisation such as a Department of State to invite the uninhibited views of those involved at a lower management tier. It is an outstanding example of open government at its best (2).

Open government is not something we are used to in Britain. The blanket cover of the Official Secrets Act protects central government from critical scrutiny. The spirit of enquiry and public discussion characteristic of scientific behaviour sharply contrasts with the 'need to know' principle on which the civil service operates: those who need to know will be told, those who do not need to know will be discouraged from finding out (3).

Although everything a Department does is said to be done in the name of its Minister, the major part of a Department's activity reflects the continuation of policies not controversial or currently important enough to warrant ministerial attention. Official commitment to such settled policies is part of the 'entrenched lethargy' of the civil service (4). To judge how far the DHSS is committed to planning we have tried to form a picture of how the Department works, in spite of the limited amount of information available to update the RHA Chairmen's Report and to supplement official publications such as the Grey Book (5) and various reports from the Expenditure Committee (6). At least part

of the explanation for the confused outcome of the rounds of regional strategic planning in 1976/7 and 1978/9 is that the NHS has not understood what the Department wanted or why. Moreover, the failure to understand is not simply due to the inability of the Department to express its wishes clearly, but also to insufficient appreciation on either side of what could reasonably be achieved. Commentators such as Klein (7) have emphasised that planning would take many years to become established and that early results from the system should not have been expected.

The task of producing plans would have been easier had there been a single purpose for them, for example, had they been viewed as reports from the Regional Health Authorities to the the DHSS about likely developments in the next ten or twenty years or about particular difficulties that authorities expected to have to face in implementing national policies. Although such an approach would have produced benefits for both sides, the public nature of NHS plans and the diversity of the audience to which they were addressed meant that they were regarded as more than reports to a head office. In this chapter, however, we shall consider planning solely in the context of the relationship between the DHSS and the Regional Health Authorities.

The Structure of the DHSS

The Department of Health and Social Security was formed in 1968 by a merger of the Ministry of Health with the Ministry of Social Security. Richard Crossman describes in his diary how Harold Wilson offered him the job of taking overall responsibility for the new department:

> Tuesday, March 19th
> I strolled across St James's Park to get my hair cut and when I got back to the office with very little to do I was suddenly told the P.M. wanted to talk to me. At once I felt that this was a talk about the future and, sure enough, when I got down there it was the most relaxed conversation I've had with Harold for a very long time. I've been very rough to him and completely aloof and now suddenly he wants to make me an offer in a major reshuffle. He started by saying he was talking in the closest personal confidence and I wasn't to tell anybody what he said. What he intended was to make me First Secretary and Minister of Social Services, which would mean combining in a single Ministry the Ministries of Social Security and Health. I paused and said I would like to think it over but my first reaction was that I ought to be Minister of Defence. 'No future there', he said abruptly. 'Maybe two years ago you could have gone there when the decisions still had to be taken. It's too late now. You would find that a dead end. You won't leave anything memorable if you go to Defence, but you could be as memorable as Beveridge is you go to the other job and make a go of the two years of reorganization there. You can have something for your memoirs,' he said, looking at me, and I was clearly aware that these are

the last two years of my political life, and he was offering me a really big chance to be right at the top with a key job and a genuine promotion (8).

One of the effects of Richard Crossman's appointment as Social Services Secretary was that ministerial responsibility for the NHS now rested with a member of the Cabinet. The Minister of Health was one of five ministerial heads of department not in the Cabinet immediately after the general election in 1966, but by March 1974 all ministerial heads of department were in the Cabinet as a result of the mergers like the one between Health and Social Security. The reform was, therefore, one of a series of changes in the organisation of central government which ensured that all Departments had a spokesman in the Cabinet (9).

The posts of Minister of Health and Minister of Social Security were retained, below the Social Services Secretary. They still exist in 1980. Other posts held in the Department by MPs are either as Parliamentary Under-Secretaries or as Parliamentary Private Secretaries. The ability of the Prime Minister to make such appointments helps to strengthen the Government. It exerts control by patronage on MPs who might otherwise be back-bench critics.

The Secretary of State has a small private office separate from the main civil service hierarchy. His Principal Private Secretary is a permanent official, with the rank of Assistant Secretary, who reports directly to him rather than to the Permanent Secretary of the Department. There may also be one or more political advisers, appointed as temporary civil servants. The Permanent Secretary, the Chief Medical Officer, and other senior officers are sometimes referred to as the Top of the Office. This term is a loose description because membership of the Top of the Office is not clearly defined. No single group or committee has corporate authority like a Regional Team of Officers has. Fluid arrangements like this help to perpetuate the dominant position of generalist administrators in the Civil Service. An organisation chart is shown as figure 1.

Late in 1970 a team was appointed to review the organisation and operation of the DHSS and to propose changes. As a result, the Department was reorganised in 1972. Its present structure dates

Table 1

Specialist heads of separate hierarchies in DHSS

Chief Medical Officer
Chief Nursing Officer
Chief Pharmacist
Chief Dental Officer
Director of Social Work Services
Chief Scientist
Chief Engineer
Chief Architect
Chief Surveyor
Chief Works Officer
Solicitor

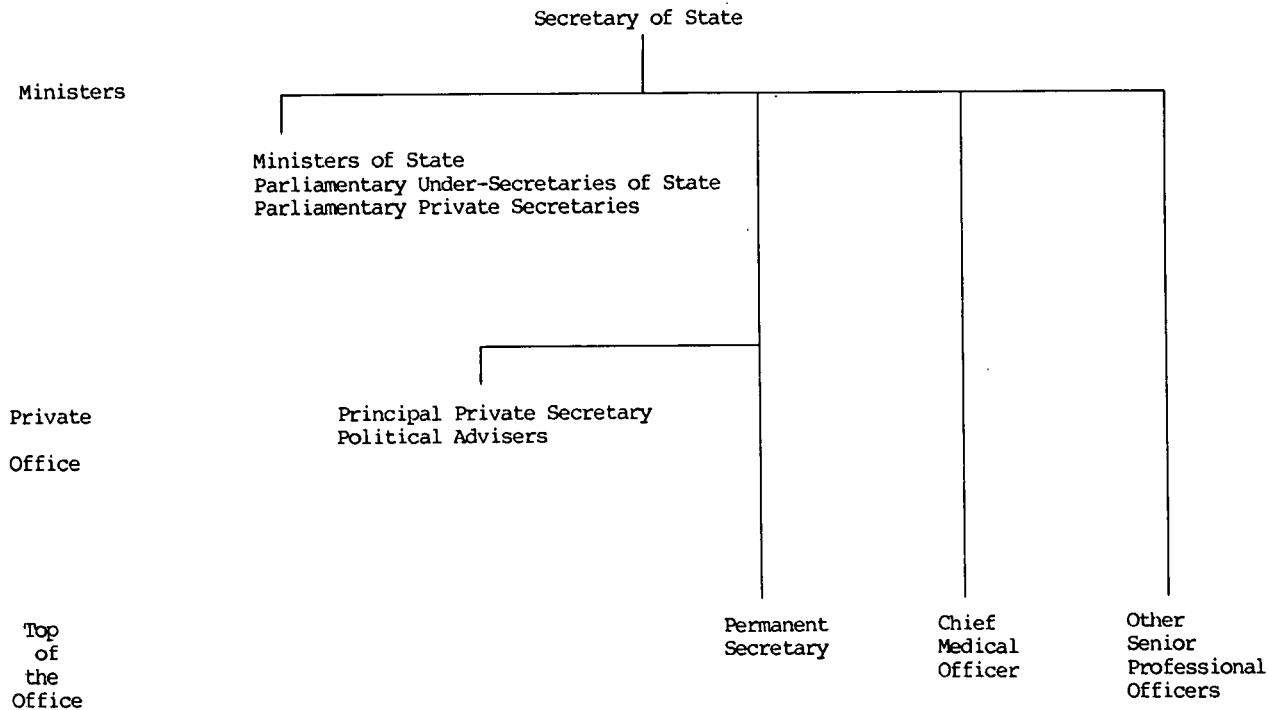


Figure 1. Organisation of the Department of Health and Social Security

from then. A feature of the new organisation was the co-ordinated hierarchies of professional and administrative staff. Separate hierarchies had existed before but they were redesigned to facilitate links between them. This was as far as the Department was prepared to go in implementing the recommendation of the 1968 Fulton Report on the Civil Service that 'administrators and specialists should be integrated in teams or unified hierarchies' (10). Professional heads are listed in table 1.

Within the DHSS as it is currently constituted, planning is mainly an administrative activity, so we have focused on the hierarchy below the Permanent Secretary. It is difficult to assess the contribution to planning made by doctors, nurses, social workers and others in the separate hierarchies in the Department, except to say that it is co-ordinated by administrators.

There are six main groups of administrative staff, each headed by a Deputy Secretary.

1. Services Development Group
2. Regional Group
3. NHS Personnel Group
4. Finance Group
5. Central Administration and Social Security Operations Group
6. Social Security Policy Group

These groups largely preserve the separation of social security from health and personal social services, except for finance and central administration, because there is a Second Permanent Secretary in charge of the social security side of the Department. This is shown in Figure 2.

Although the six groups are broadly the same today as in 1972, there have been changes. To discuss these we need first to clarify some terms used to describe the administrative hierarchy.

Each group is headed by a Deputy Secretary and contains about five divisions.

Each division is headed by an Under Secretary and contains about three or four branches.

Each branch or unit is headed by an Assistant Secretary and contains about two or three sections.

Each section is run by a Principal with the help of executive officers. The number of executive officers in a section varies widely according to the type of work.

The changes since 1972 have been through the contraction or expansion of divisions by merging, hiving-off or take-over of branches. There has also been some movement of divisions between groups.

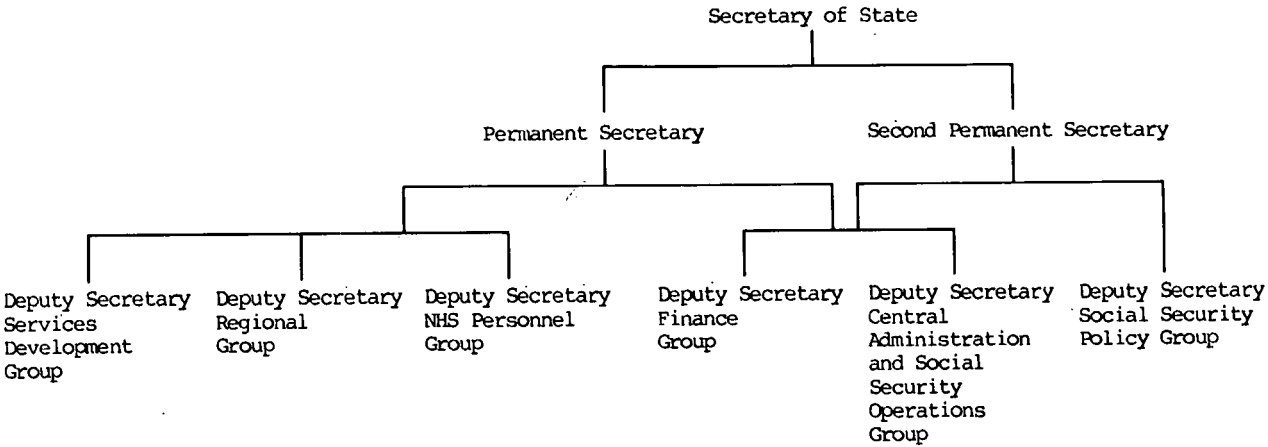


Figure 2. The Permanent and Deputy Secretaries of the DHSS Administrative Hierarchy

The Services Development Group

A brief description of the Services Development Group's intended role in planning was given in an appendix to the Grey Book.

> As part of its method of operation, it is proposed to introduce a planning system which will help the Department, in association with Health Authorities and local authorities, to assist the Secretary of State decide national objectives and priorities. One of the six organisational commands, the Services Development Group, will be primarily responsible for developing national policy to improve health and personal social services and will play a major part in the planning process. It will give special attention to assessing people's overall needs. In the Group will be branches concerned with particular groups of people such as the elderly, the physically handicapped, the mentally disordered and children, but it is proposed that the emphasis in all branches should be on people's needs for services and how these can best be met (11).

Table 2

The Divisions and Branches of the Health and Social Services Development Group (1972)

Health Services Division (I)
Health services planning
Primary and community health services
Health services for children
Preventive health services
Health Services Division (II)
Specialist medical services
Specialist surgical services
Hospital management and organisation
Scientific and technical services
Local Authority Social Services Division
Approved schools, remand homes
Treatment centres
Children at risk and their families
Residential and field services
Planning and development
Social Handicap Division
Elderly
Physically handicapped
Services for the single homeless
Alcoholics, drug addicts
Mental Health Division
Mentally ill
Mentally handicapped
Special Hospitals
Environmental Health Division
Medicines
Food - nutrition, safety, hygiene
Pollution and contamination

At the time of implementing the review team's report in 1972 the Services Development Group was organised into six divisions each with three or four branches, as shown in table 2. These branches are often referred to as policy branches which tends to emphasise that they have no responsibility for implementing the policies they help to formulate, at least as far as the NHS is concerned.

It is unclear what will happen in the next few years following the reductions in civil service manpower which the present government intends to implement. However, at the time of the last election (May 1979) the Services Development Group had evolved into a somewhat different shape, that was nonetheless similar in its component parts to its original structure in 1972. This is shown in table 3.

One of the most striking features of the Services Development Group is the relatively small coverage of acute hospital services compared with their dominance in the NHS. This came about because there was particular concern at the time of DHSS reorganisation in the early 1970s about gaps and deficiencies in the NHS, especially

Table 3

The Divisions and Branches of the Services Development Group (1979)

Health Services Division (I)
Abortion, family planning, smoking and health
Health education and prevention
General public health issues
Food hygiene and safety standards
Health Services Division (II)
Specialist medical services
Specialist surgical services
Scientific, technical and support services
Health services planning
Local Authority Social Services Division
LASS/NHS collaboration, general social policy questions
LASS planning, training, voluntary work
Services for the elderly
Services for the physically handicapped
Mental Health Division
Services for the mentally ill
Services for the mentally handicapped
Special hospitals
Services for homeless, alcoholics, drug addicts
Children's Division
Juvenile delinquents, community homes, youth treatment centres
Children at risk and their families
Child health
Adoption
Other Branches
Health services organisation and administration
Policy planning unit

the inadequacy of services for long-term care. The Department decided to put its main effort into developing non-acute services, on the assumption that powerful interests elsewhere would ensure that acute hospital services were not neglected. There would also have been the attraction of winning extra funds in PESC negotiations, in Cabinet if not in the Treasury, by touching political soft spots with arguments about avoiding further scandals by directing some resources towards improving the standard of long-term care.

The concentration on neglected groups and politically sensitive issues was criticised in the report of the RHA Chairmen who felt that there was an absence of informed policies about the acute services. They implied that the Department was not so much giving a strong lead by developing policies for neglected groups, but steering clear of 'those areas which experience has shown difficult to penetrate (the acute services) save along the periphery (domestic services, chaplains)' (12). Planning involves the capacity to control as well as to develop services. Given the prestige of the acute sector and the acceptance of the doctrine of clinical autonomy, it is not surprising that the health authorities felt in the economic climate of the mid-1970s that they could barely contain the pressure to expand the acute services, let alone devote resources to speeding up improvements in other sectors. This problem has dominated planning from 1975 onwards.

From the health authorities' point of view, the Department's policies (emanating from the Services Development Group and the parallel professional hierarchies) are unsatisfactory in two respects. First, they provide inadequate means of controlling the acute sector, and that is the key to enabling the development of services in other sectors. Second, they make their own additional demands for non-acute services without providing the means for meeting these demands. The DHSS encouraged and often supported hospital closures to reduce the number of acute beds in places where they were relatively plentiful. Support for such closures, however, was more evident when local opposition was weak. When proposed cuts led to confrontations, the health authorities soon realised that they could not rely on ministerial backing.

It is perhaps not difficult to understand why the Regional Chairmen dismissed the work of the Services Development Group as being neither practical nor relevant to the NHS, for they could see that there was little hope of making headway with non-acute services until something was done to reduce the capacity of the acute sector to expand faster than other services. Essays in persuasion, in the form of central guidance on priorities, tended to irritate rather than help, because they showed how little the Department appreciated the practical problems of management and planning in the NHS.

The Regional Group

The establishment of the Regional Group in 1972 was tied in logically with one of the purposes of NHS reorganisation which was to enable a comprehensive health service to be organised and planned on a geographical basis. Attention had previously been focused

mainly on the institutions supplying health services. The emphasis was to be shifted from an acceptance of the current patchwork of supply to an attempt to establish and then provide what local populations needed. The client group approach was one way of classifying the needs of a population both locally and nationally. Adding together the needs of one client group across all the areas in the country would show what was required nationally for that group. Adding together the needs of all the separate client groups in a locality would show what the total needs of the area were. The two approaches - client group and geographical - could be considered either as alternative or as complementary ways of determining the needs for health services.

It was mainly to avoid confusion that the Regional Group was given the responsibility for developing and maintaining contact with the health authorities. This hindered the Services Development Group's promotion of client group policies, although the geographical basis for the allocation of finance was a far more serious obstacle.

Following the summary in the Grey Book of the Services Development Group's activities was a brief description of the Regional Group.

> Another organisational command, the Regional Group, will be the main link with RHAs and local authorities and will be organised on a geographical basis. The Group will assist Health Authorities to produce and implement plans which will give effect to national policies while taking full account of local circumstances, priorities and policies. It will also ensure that Health Authorities receive any help that they need from the Department. More staff than in the past will be allocated to this work. They will normally be centrally-based, not out-posted (13).

Although the Regional Group was formally set up in 1972 in the reorganisation of the Department, its work was somewhat less clearly developed than some of the other groups (see table 4). The Health Services Organisation Division was mapping out the structure and management arrangements of the reorganised NHS, while the two Regional Divisions had the more practical task of liaison with the emerging health authorities. No doubt the trauma experienced in NHS administration had its counterpart in frenzied activity in this part of the Department.

By the time of the change of government in 1979, the Regional Group had undergone some changes, with a new distribution of work reflecting the growth or contraction of activities (see table 5). The main differences between 1972 and 1979 are the disappearance of two of the Divisions and the splitting of two others. Traces of the Health Services Organisation Division remain in one of the branches in Regional Liaison II and in a branch of the Services Development Group. The Building Division has become part of the Works Group under the Chief Works Officer, so it has moved outside the main administrative hierarchy. The emergence of a new division for industries and export out of the Supply Division is not of particular interest as regards NHS planning, but the formation of a new division to deal solely with planning and liaison in the

Table 4
The Divisions of the Regional Group (1972)

Health Services Organisation Division
Reorganisation of NHS
NHS reorganisation management study
Regional and Planning Division
Regional Division
Supply Division
Disablement services
Hospital Supply
Scientific and technical services
Industry and export
Policy and prices
Building Division

Table 5
The Divisions and Branches of the Regional Group (1979)

Regional and Central Planning Division
Resource allocation and programme management
Regional planning
Policy planning unit
Regional Liaison Division (I)
Liaison with East Anglian, Oxford, West Midlands, Wessex, South Western RHAs
Liaison with Northern, Mersey, North Western, Yorkshire, Trent RHAs
NHS organisation management, communications and liaison with policy divisions
Regional Liaison Division (II)
Liaison with the four Thames RHAs
Co-ordination of planning in the Thames Regions
Supply Division
Disablement services
Health Service supply branch
Scientific and technical services
Mobility of physically handicapped
Industries and Export Division
Home industries
Exports
Prices

London area is very significant. It reflects an awareness that the key to implementing national priorities for health services lies in the control of the acute services in London.

It has been a distinctive feature of the Regional Group's style of working to set up joint DHSS-NHS committees such as the London Health Planning Consortium, the Resource Allocation Working Party and the Standing Group on Planning. The chairmen and secretariat

of the committees are DHSS officials, so that what emerges from them is predominantly a Departmental view. Nevertheless the recommendations that do emerge have a greater impact on NHS administrators and planners than the products of anonymous officials. The list of members published in such papers as the RAWP Report creates the impression that the NHS is strongly represented, with NHS and DHSS members roughly equal in number and the NHS representatives coming from the top levels of management. The composition of joint committees is carefully balanced to ensure that it reflects a wide geographical coverage and includes the main professions in NHS management, such as administrators and treasurers as well as medical and nursing officers. The purpose of all this is to increase commitment throughout the NHS to what comes out of these committees.

In its role as the main link between the health authorities and the DHSS, the Regional Group was better placed than the rest of the Department to sense and respond to the need for developing new ways of influencing the NHS other than through the issue of letters and circulars. So much paper came out of the DHSS in connection with reorganisation that ignoring it became part of a strategy for survival. Brown described it as 'a sea of paper in which few people were able to keep afloat' (14). Watkin confirms the alienation of the NHS.

> A steady stream of paper poured out of the DHSS, refining and developing earlier guidance and creating the impression of a central department determined to control every detail, but hardly able to coordinate the work of its own divisions. Courses were organised at national and regional centres to brief staff on the principles of the reorganised NHS and to introduce them, inter alia, to the delights of the new and formidably documented NHS planning system. By this time many senior officers and members of authorities were discovering unexpected virtues in the existing structure of the services and wondering whether structural reorganisation would in fact prove the answer to the problems it was designed to solve. (15)

The establishment of joint DHSS-NHS working parties run from within the Regional Group was more productive than the methods used before. Not that there has been a dramatic change in the relationship between officials in health authorities and those in the Department. The closer working together implied by the setting up of joint committees is more symbolic than real.

Regional and Central Planning Division

The division directly concerned with NHS planning, the Regional and Central Planning Division, was known as the Regional Planning Division until the central planning branch moved across to join it. It was intended that there should be interaction between central and NHS planning, that guidelines would influence plans and that plans would have some effect on future guidelines. By 1979 the central planning branch had evolved into the policy plan-

ning unit in the odd position of being in both the Regional and Central Planning Division and the Services Development Group. This peculiar structural change is a reflection of the difficulty of achieving co-ordination between the Services Development Group and the Regional Group, between formulating and implementing policies, between guidelines and plans, between central and local planning, between the DHSS and the field authorities. The attempt by the Department to enmesh central and NHS planning has not yet succeeded, mainly because guidelines have been unrealistic and the DHSS has little power to enforce them. The RHA Chairmen showed some appreciation of the problem when they spoke in 1976 of 'political and organisational uncertainties' and concluded that 'the interaction between the planning systems of the Department and the Service has not been thought through in detail ..... and there is evidence that it might in any case have been a disjointed exercise' (16).

Another aspect of co-ordination apart from the desired link between central and health authority planning is the connexion between plans and resources. (The Chairmen's report had commented that there were more policies than money.) One branch of the Regional and Central Planning Division in 1979 has had a continuing responsibility for resource allocation including the development of the RAWP proposals. The branch is concerned with both capital and revenue allocations and with such issues as the revenue consequences of major capital schemes. Throughout the period covering the introduction of strategic planning into the NHS the functions of resource allocation and the development of regional planning have been as close as possible in terms of location in the DHSS administrative hierarchy, although the two processes were kept distinct.

The Regional Planning Branch

Given the veil of official secrecy and the 'need to know' principle (17), it is difficult to say exactly how long the regional planning branch had been in the form that it was in when the Conservatives came to power in May 1979. At that stage the branch (known as RCP2) was divided into two sections:

RCP2A NHS plans, guidelines, planning reports;
RCP2B NHS planning system.

It is probable this arrangement could be traced back to 1976, covering both rounds of regional strategic planning. The division of labour between the two sections was that RCP2A was more directly accessible to the NHS generally, whereas RCP2B provided the secretariat for committees such as the DHSS-NHS Standing Group on Planning.

The role of RCP2A is illustrated in a letter to Regional Administrators from the Under-Secretary of the Regional and Central Planning Division. The letter dated 11th January 1978 accompanied a draft addendum to the Planning Manual (18) and told (or reminded) administrators that they were 'to continue work on strategic plans ..... with a view to submitting to the Department in January

1979 revised regional strategic plans'. The letter also stated that:

> The Regional Planning Branch of DHSS will be glad to help Regions in any way they can with technical problems in strategic planning.

It went on to give the names of the Assistant Secretary of the Regional Planning Branch and the Principal of RCP2A, saying that enquiries should be addressed to them. It also named a statistician attached to the Regional Planning Branch who would deal with enquiries on statistical matters.

The statistician was one of three technical support staff attached to RCP2A who were known as the Central Analytical Team. The other two were an economist and an operational researcher. Their main function was to analyse the numerical aspects of NHS plans with the aim of checking conformity with guidelines and producing a national summary of the plans. This turned out to be no easy task. There were links between the team and the Regional Liaison Branches. Rather than working together on all the plans, each one looked only at plans from Regions covered by the part of Regional Liaison he was linked with. Although this style of working satisfied the bureaucratic principle of a clear definition of roles it discouraged cooperation within the team, leaving each member to develop his own mode of unravelling and sifting through plans. On the other hand, the division of labour fitted in well with the organisation of Regional Liaison.

The first point of contact between any RHA and the DHSS is the Regional Principal, a member of one of the Regional Liaison branches who is specifically assigned the task of dealing with one or possibly two Regions. Whenever appropriate, the Regional Principal combines with professionals from various parallel hierarchies in the Department to form a Regional Liaison Team. Within this system the processing of NHS plans connected the members of the Central Analytical Team with particular Regional Principals and Liaison Teams. The discussions between the DHSS and the RHAs about individual plans took place at both formal and informal meetings involving different officials as appropriate. These were occasions, therefore, when members of the Regional Planning Branch, particularly the Assistant Secretary, the RCP2A Principal or the appropriate CAT member, went out to health authorities to see at first-hand how the planning process was developing.

By comparison, the Principal of the other section of the Regional Planning Branch had a less roving brief. His concern was the theoretical framework of the planning system not its implementation. This mainly involved committee work in the DHSS, and included regular meetings with service planning administrators from the RHAs. In other parts of the Department it is also standard practice to arrange several meetings a year between the DHSS and professional equivalents in the Regional Health Authorities. The meeting at which David Owen invited the Regional Chairmen to form a team to examine the working of the Department illustrates the pervasiveness of such contacts. Such meetings of representatives from all Regions have led to the development of links outside the mechanism of regional liaison, whereby each Region is

connected separately with a section in the DHSS whose sole task is to maintain liaison with that Region.

It had originally been intended that planning would be the principle instrument of central control over the health authorities. The very limited ability of the DHSS to examine and monitor plans seems to have been overlooked. A result of the slowness with which planning was introduced into the NHS was that the relationship between the health authorities and the regional liaison branches of the Department developed not so much in connexion with broad issues of strategic planning as in resolving the more immediate problems of management. How this was perceived in the the NHS can be deduced from the report of the RHA Chairmen's enquiry. In the short, sharp summary of their conclusions and recommendations they wrote:

> The Regional liaison function should continue to explain DHSS policy, and to monitor, but not to meddle. Its staffing should be reduced (19).

This was followed by an even more severe judgement on the Services Development Group:

> The policy functions of the Services Development Group should be performed in a radically different way. There should be a small nucleus of staff, flexibly employed in the formulation of policy, and drawing heavily on Health Service experience .....It is essential to have a strong mechanism for ensuring that work in DHSS is done only on policy that is relevant and practical (20).

In theory at least, a well-developed planning system would do away with the need for detailed central control. Approvals for major developments which would strongly influence spending commitments for many years would be given in the context of a strategy spelt out in a comprehensive plan. Provided that health authorities followed such a centrally approved strategy and kept within cash limits, there would be little or no justification for further sanctions. Even in the absence of a developed planning system, the Department is too much concerned with detail. This can be illustrated by looking at the work of a third major group in the DHSS, the NHS Personnel Group.

The NHS Personnel Group

All that the Grey Book had to say about the NHS Personnel Group was:

> A third command will be the NHS Personnel Group. This Group will be organised mainly around the principal groups of NHS staff and will also have one division which will take the lead on developing personnel policies generally (21).

A memorandum submitted to the House of Commons Expenditure Committee was a little more explicit.

Table 6
The Divisions and Branches of the NHS Personnel Group (1979)

Doctors Division
Hospital doctors and dentists pay and conditions
Medical and dental manpower, and post-graduate education
Remuneration of general medical practitioners
General Practice (excluding remuneration)
Doctor's prescribing
Pay Policy Division for Administrative, Scientific and Ancillary Staff
Professional and technical staff
Administrative and clerical staff
Manual and maintenance workers, and ambulance workers
Professions supplementary to medicine, speech therapists and chaplains
Division for Dentists, Nurses, Opticians and Pharmacists
General dental services and community dental services
General pharmaceutical and opthalmic services
Chemists remuneration and terms of service
Nurses and midwives pay and training
NHS Personnel Services and Superannuation Division
NHS National Staff Committee
NHS training and superannuation policy
General NHS personnel and manpower matters
Medicines Division
Medicines Act policy and enforcement
Licensing under Medicines Act
Professional aspects of Medicines Act
Biological products
Medicines inspectorate

> The main functions of this command are to negotiate (mainly through the Whitley Council system) pay and conditions of service for all NHS staff, to help the NHS to recruit and train the staff it needs and to plan the manpower supply for the key professions. The command consists of 5 divisions, one of which covers the subject of the safety, efficiency and quality of medicines (22).

These brief official descriptions give little of the flavour of the group's work, even when they are supplemented by details of the branches within the divisions (see table 6).

The Regional Chairmen's Report, whatever its shortcomings in objectivity, did at least convey an impression of what the group's activities look like from the health authorities' viewpoint. The frustration and sense of waste show up clearly.

> What the enquiry team does not accept is the necessity for the detailed case load of minor points of interpretation which are referred to the Group. There seems to be little practical advantage to be gained from the intervention of the Department in every case where there is a departure, however

> slight, from national terms and conditions of service. The process is tedious, the advantage to either Department or Service is minimal, and the frustration inflicted on those operating the Service is very considerable. The enquiry team recommends in the strongest possible terms that all such case work should be immediately devolved to field authorities .... Too often in the NHS, authorities are forced under existing regulations to employ staff of inadequate calibre, when fewer - but better - people would produce a much more effective result. (23)

The Department's main control of NHS manpower is in its power to sanction new posts. This extends far beyond the power to veto the establishment of consultant posts in hospitals, which is an important control in view of the extensive resources which consultants use in their work. Even more significant is the link between the specialty of a consultant and the type of patient whose needs will be catered for. Clearly, services for the elderly are more likely to be improved by the appointment of a geriatrician than a paediatrician. Although other services are less directly related to particular age groups, there are associations between the demographic features of a population and the balance of health services needed. Control over the allocation of new consultant posts is necessary to ensure development of services in accordance with Government priorities. What appears unnecessary, in view of cash limits and the success of the 1976 exercise to reduce management costs, is the sanction, for instance, over middle grade administrative posts (above scale 9) which has adverse effects on career patterns and recruitment in the NHS. The Chairmen listed several objections (24). In particular, they observed that the need for approval for any variation of Whitley Council agreements generated an enormous traffic. The Thatcher administration might find scope for cuts in the NHS Manpower Group. This would please health authorities as a gesture of confidence in their cooperation to achieve the Government's objective of reducing NHS administrative costs by a further £30 millions.

The Finance Group

The Finance Group 'contains three divisions, two concerned with health and personal social services and one with social security. Their functions include negotiation of resources for the Department's services, assessment of the financial implications of proposed policies, and accounting for the Department's votes' (25).

Two of the three functions of the Finance Group given in this brief official description are connected with the Department's planning system. First, the negotiation of resources for the Department's services mainly takes place within the PESC system and influences the financial guidelines given to policy branches in the Services Development Group. Second, the assessment of financial implications of proposed policies is none other than the use of programme budgeting to put a cost on the suggestions appearing in planning statements. A lecture handout prepared in the Finance Group's PESC and programme budget branch illustrates

1978	Central Government	DHSS	NHS
March	Public Expenditure Survey Committee (PESC) starts up.	a) Issue cash limits to Regions. b) Planning guidelines based on 1977 PESC issued to NHS.	
April	PESC discussions between DHSS and Treasury (using material produced in DHSS and NHS planning systems).		Regions issue guidelines to Areas (Operational and Strategic), including cash limits.
May	a) PESC discussions continue. b) Public Expenditure Committee considers broad plans. c) Public Accounts Committee queries specific items.		Areas issue operational guidelines to Districts.
June	Confidential PESC report finalised.		
July	Cabinet studies PESC report.		a) Area plans approved for consultation. Regions prepare strategic plan. b) Annual Planning Reports to DHSS.
August		Planning round begins formally.	
September	Further Cabinet studies of PESC report.		
October/November	PESC decisions taken		a) End of consultation on area plans. b) DMTs submit district operational plans to areas.
December		a) Issue volume allocation for 1979 - 82. b) Production of trial Programme Budget (PB) based on 1977 - 78 costing data and DHSS planning statements.	Areas submit operational plans to Regions.
1979			
January	Expenditure White Paper published	Ministers consider new planning guidelines.	Regional Strategic plans due.
February		End of DHSS formal planning round.	
March	Public Expenditure Survey Committee starts up.	a) Issue cash-limit allocations 1979 - 82. b) Planning guidelines based on 1978 PESC issued to NHS.	

Figure 3
A Planning — Allocation — Monitoring Timetable

how the NHS planning system is seen from that angle (see figure 3). The timetable is perhaps more a reflection of how the planning system ought to work than how it does work. Nevertheless the timetable does show how NHS plans could ideally provide some basis for the PESC bids prepared by the Finance Group.

Evidence was given in 1976 to the Expenditure Committee about the role of planning in enabling central control of the NHS and accountability.

> A broad financial control is exercised by giving RHAs fixed allocations, which they must not exceed but within which they have considerable freedom to manage as they judge best. The essential counterpart to this degree of delegation is a clear line of accountability and an efficient system of monitoring. This is largely assured by the inter-active nature of the NHS planning system, but this must be backed by good financial information and analysis (26).

The NHS planning system could not have assured anything in the state it had reached by 1976, but the statement throws some light on the relationship between the NHS and DHSS as seen by the Finance Group. The group's own priority is to have good financial information to satisfy the requirements of Parliament and the Treasury. Estimates have to be prepared for presentation to Parliament so that funds can be voted to the Department for distribution to health authorities. The accounts kept by health authorities are audited by the Department and summarised for scrutiny by the Public Accounts Committee. One of the major concerns of the Finance Group is to ensure that the Permanent Secretary is not embarassed when he appears before the Public Accounts Committee as the Department's Accounting Officer.

The Finance Group has recently acquired the Economic Advisers' Office and the Statistics and Research Division, which were previously part of the Central Administration Group (see table 7). There are two possible reasons for this expansion of the Finance Group: to broaden the perspective of the group or to relieve the

Table 7

The Divisions of the Finance Group (1979)

Planning and programming for health and personal social services*
Financial control of health and personal social services**
Financial control and planning of social security
Statistics and research
Economic adviser's office

* Deals with PESC and programme budgeting
** Deals with parliamentary estimates and accounts for health authority expenditure

Deputy Secretary of the Central Administration Group of a rather heavy workload. It is likely that balancing out the work of the groups was the more pressing reason. The weight of central administration, however, and the social security side of the Department's work are not of immediate interest in this study.

The Policy Planning Unit

One branch of key significance in understanding the Department's interest in NHS plans is the branch concerned with the Department's own planning system. A long range planning branch was set up in the Ministry of Health in the mid-1960s. The planning branch has undergone various changes in the past ten years or so, including changes of name, but it is still in existence in 1980 as the policy planning unit. At the time of the restructuring of the Department in 1972, following the review team's report, the planning unit was placed in the central administration group. The unit was known at that time as the central planning unit. It became part of a new central planning services division, which also contained a management services unit, an operational research branch, and a team working on programme budgeting.

According to Razzell (27) the planning unit then began to get heavily involved with developing and co-ordinating an annual planning system within the Department, in line with the review team's recommendations. The branch moved to the Services Development Group, then to the Regional Group, before being moved again to a position between the two groups. Such a strategic location may have been designed to create a more effective link between services development and regional liaison. Whatever the case, the planning branch has been one of the more mobile parts of the Department's administrative hierarchy.

In 1979, the policy planning unit (PPU) had three sections:

PPU1 Secretariat for the Health and Personal Social Services (HPSS) Strategy Committee;
PPU2 Departmental planning system;
PPU3 Review of information.

The HPSS Strategy Committee is chaired by the Permanent Secretary. In providing the secretariat for this committee, PPU1 is linked with the Top of the Office. The Strategy Committee looks at the broadest issues and, as one civil servant put it, 'gives a sense of direction and purpose to the planning system'.

At a second level there is a planning steering committee chaired by either the Deputy Secretary of the Services Development Group or the Deputy Secretary of the Regional Group. Who takes the chair at a particular meeting depends on the agenda. The secretariat for the planning steering committee is provided by PPU2. The role of the planning steering committee is to oversee planning not only in the Department but also in the National Health Service and Local Authority Social Services (LASS). This would explain the joint chairmanship of the committee because Departmental and LASS planning falls within the Services Development Group whereas the Regional Group would be concerned with NHS planning. PPU has the

task of co-ordinating the various planning activities within the Department.

The DHSS Planning System

A brief description of DHSS planning appears in the minutes of evidence given to the House of Commons' Expenditure Committee in 1977:

> If I could just comment on the point about reporting on these matters to Ministers. It may be helpful to know that for two or three years now, as a foundation for the work on the National Health Service planning system, for each section of the Service an annual report is made within the Department on all these trends which are visible, and on expenditure implications and so on as part of what we call 'Group Planning Statements'. Therefore, even if there were not a particular occasion to make a report on the effect of a particular change in charging structures or something of that kind, there is a regular reporting system established within the Department which looks at each group of services as a whole, and draws attention to up-take problems and similar features (28).

There are two points to note about this piece of evidence. First, the Department's planning system was put into operation well before the first round of NHS strategic planning. Second, quite independent of the connexion with NHS planning, the Department's annual planning system has a role to play in presenting Ministers with broadly-based information. NHS plans could potentially improve the quality of this information, but the system can operate without them.

The Departmental planning system follows a different timetable from the NHS planning system. This happens for two reasons. First, the output of the Departmental system forms the basis of guidelines to health authorities and therefore needs to precede the start of the NHS planning cycle. In theory, it would use the results of the previous cycle of NHS planning. In practice, the input from NHS plans has been minimal. Second, guidelines for planning are based on PESC. The liaison between the Treasury and finance officials in the DHSS during the PESC negotiations means that departmental planning can proceed within the upper and lower projections of PESC well before the public or the NHS learns of Cabinet decisions, but nothing can be published until the public expenditure white paper appears. One aspect of the policy planning unit's co-ordinating role is to obtain PESC information from the Finance Group, so that the planning steering committee can issue guidelines to the Services Development Group to form the basis of planning statements. The policy planning unit eventually consolidates these statements and produces a summary for the planning steering committee.

The content and quality of planning statements produced by the policy branches within the Services Development Group can only be guessed at because they are not generally made available. However,

the planning guidelines that are eventually issued to the NHS and local authorities give some idea of what a complete set of planning statements looks like after some stages of refinement. One such refinement (or appendage) is the costing procedure of programme budgeting.

The DHSS programme budget methodology varies slightly from year to year, as different assumptions are made or better information becomes available. Only once has a detailed description of the calculations been issued, in connexion with the figures given in the DHSS planning guidelines for 1978/79 (29). Even within the DHSS, the procedure and its subtle changes tend to be regarded as mysterious and impenetrable.

It seems to have been intended that the programme budget should be used in the Department 'to provide a relatively simple framework, within which the recommendations emerging from policy reviews could be brought together, and priorities considered in terms of the pace of implementation' (30). In practice, its effectiveness was thwarted by the difficulty of costing some of the policies put forward and the reluctance of Ministers and policy branches to accept financial constraints. Financial information systems in the NHS are under-developed, and the cost of new policies is uncertain because the response of the health and local authorities is difficult to gauge. This accounts for the lack of integration between detailed policies and the programme budgets that have appeared in DHSS guidance to health authorities. A similar disjunction is seen in regional strategic plans where the link between the text and numerical information is often far from clear. A DHSS official has described costing methods as 'very rough and ready' and 'not good enough to support the use of the programme budget as a tool of manpower planning, interactive planning and monitoring' (31). After 1978, the national programme budget was dropped from planning guidelines. There had been confusion about how individual health authorities should interpret the national figures.

A major criticism of the Departmental planning system is that the Services Development Group which produces the planning statements is so organised that its policy branches tend to pursue sectional interests in an unconstrained way. It does not have to face the problems of running the NHS and reconciling competing claims on resources. It does not even have direct contact with health authorities, since that is the special task of the Regional Group. Of course, the policy branches do have informal contacts in the NHS, but these tend to be with individuals connected with the particular area of national policy the branch deals with. Their contact with various pressure groups and professional advisory committees helps to ensure that they have a good idea of the inadequacy of the services for a client group such as the mentally handicapped or the elderly, but they are not disciplined by the financial problems which the health authorities have to face in trying to provide a comprehensive health service.

There are instances when policies seem inextricably linked with individuals in particular policy branches of the Services Development Group, and their continued presence is an obstacle to flexibility and changes in thinking. The main problem, though, is not connected with personalities but with the slow response of the

system. After the introduction of cash limits, it was work on services contraction, not services development, that was needed urgently. Without releasing resources from the acute hospital sector there was little opportunity for developing other services, because the money was not available. The remoteness of the policy branches from the struggle to manage on a tight budget alienated the health authorities. Programme budgets set in the Department's planning system did not constrain the policy branches as effectively as cash limits put a brake on developments in the NHS. The criticism of the Fulton Committee (32) that senior civil servants prefer to regard themselves as advisers on policy to people above them, rather than managers of the administrative machine below them, suggests why the DHSS appears so unrealistic to the health authorities: the Civil Service is more concerned with the procedures of policy making than with achieving results.

One major influence on NHS planning, conspicuously absent from the central planning system, is the effect of the RAWP formula on the distribution of resources between health authorities. Although it might be argued that the main concern in developing national priorities is the distribution between client groups and that the distribution between geographical areas is an entirely separate issue, it is clear from practical experience in the NHS that the two approaches need to be reconciled. The failure of the DHSS to adopt an integrated approach to planning and resource allocation reflects the structure and working of the Department. The Services Development Group works separately from the Regional Group. Services Development and Finance are tenuously linked by PESC and programme budgets, but these are unco-ordinated with RAWP and the work of the Regional Group.

When health authorities started to plan in the rational and comprehensive manner set out in the planning manual (33) they were confronted with a vast problem, which was the sheer complexity of the changes implied by any pattern of services reflecting the priorities set out in the 1976 Consultative Document (34) and the RAWP recommendations (35) published in the same year. The Department had little appreciation of the capabilities of the health authorities to absorb all the guidance showering down on them while they were reducing management costs and adapting to stricter financial controls in the form of cash limits. Nor did the DHSS satisfy the health authorities' expectation of strong support when protests came from those who stood to lose if government policy were implemented.

The slowing down of the rate of growth of resources, coupled with the expectations of increased resources for client groups and geographical areas identified as priorities for development, made it necessary for health authorities to consider cutting existing services in some areas to release resources for redeployment elsewhere. This was a radical change from the incremental improvements of the previous 25 years, and it prompted some major power struggles within the NHS. Greater control was called for as cash limits were enforced. The planning system had been designed as the main control mechanism, but it was only just being put into operation.

There was a serious failure in the DHSS to appreciate that it would take a long time to develop the system to a stage where it could function as intended. The Department was under the illusion

that because it had designed a planning system and got the central part working, it could now assume that the whole system worked. We saw that the Finance Group was claiming as early as 1976 that the NHS planning system justified the freedom given to health authorities 'to manage as they judge best' (36) within a fixed allocation of cash. If approval of plans were to become the formal basis of the annual allocation of funds to health authorities, then planning would be of major importance.

Planning for Personal Social Services

It had been intended that the NHS planning system would interlock with local authority planning for social services. In 1972, a year after the establishment of unified social service departments, the Secretary of State, Keith Joseph, requested ten year plans from local authorities despite the impending reorganisation of local government. The DHSS abandoned its attempt to introduce ten year planning for local authority social services after the first set of plans were produced in 1973. The plans were never revised. At first, the intended revision was delayed by the local authorities' objections to undertaking such an exercise while they were coping with the more immediate problems of local government reorganisation in 1974. Before the DHSS could get round to insisting that the ten-year plans should be updated, the economic crisis in 1975 and large cuts that were made in the PESC forecasts made long-term planning for social services seem futile to the local authorities. Booth argues that this undercut the value of planning because local authorities had little choice but to maintain their present commitments, and it also brought long-term planning into disrepute by showing the unreliability of resource assumptions (37). The DHSS gave up the idea of asking for a repetition of the 1972-3 exercise, and a much simpler three year planning system was introduced in 1977 which was tailored to link the development of social services with the resource assumptions of PESC.

Following the 1979 election, the Conservative policy of reducing local authority spending, while allowing the authorities to choose which services to cut, meant that financial assumptions for personal social services were too unstable to make three-year planning viable at that time. The 1979-80 exercise was cancelled, but the option has been kept open for 1980-81. The DHSS would like the system of annual planning statements covering three years to become established, although it cannot proceed without the agreement of the local authority associations.

There are enough differences between the NHS and local authorities and between health and personal social services to make it foolish to deduce that the story of social services planning will necessarily be repeated for health services planning. The NHS has not suffered such extensive cuts in planned expenditure; its planning horizon needs to be further ahead because of the scale and fixedness of its major investments in capital (i.e. hospitals) and manpower (eg. doctors and especially consultants); and the health authorities cannot resist DHSS pressure quite as effectively as the local authorities. On the other hand, a simplified system has been promised (38), and the Government's policy of strengthening

local management has led DHSS officials to speak of 'disengagement' and 'not wanting to pull levers to influence the NHS'. The current pre-occupation of the health authorities with the restructuring exercise of abolishing AHAs will give the DHSS a breathing space to consider how best to change its methods of working in relation to the NHS to reflect the emphasis on local management.

The DHSS After the 1979 Election

Since May 1979 there have been significant changes in the DHSS. Most notable is the dismantling of the Regional and Central Planning Division and the upgrading of the policy planning unit to be a division in itself, instead of one of several branches within the division. The policy planning unit now has an Under Secretary at its head rather than an Assistant Secretary, but it is still not a match for the Deputy Secretaries that it is wedged between, let alone a rival for the Permanent Secretary, as suggested in the Fulton Report.

When the Fulton Committee recommended the establishment of planning units it had something different in mind from the kind of unit that has developed in the DHSS. A member of the Fulton Committee has described recently its strategy, to make:

> recommendations that, while chiefly designed to eradicate other civil service faults, would also undermine the old mandarin mentality. Perhaps the most important proposal in this latter category was that each department should have a Planning Unit. Departments were so involved with the current issues of the moment that few civil servants found, or made, the time to look ahead. So a newly created Planning Unit in each major Department was to become responsible for 'long term policy planning and research'. It would also be job of the Planning Unit to see that the department's day-to-day policy decisions were consistent with long term strategies. To be successful in both roles each unit had to be staffed mainly by specialists. The head of each Planning Unit - who would become the department's Senior Policy Adviser - would certainly have to be a specialist. And he would have direct access to the minister. As a consequence he would break the grip of the Permanent Secretary and his fellow generalists on the policy making process (39).

The DHSS planning unit contains no specialists, its head is not a specialist, nor does he have direct access to the minister. Far from being a challenge to the Permanent Secretary, the planning unit is almost totally dependent for its effectiveness on how much interest the Permanent Secretary takes in it.

The branch of the Regional and Central Planning Division which used to deal with resource allocation has been transfered to the Finance Group, but the branch most familiar to NHS planners has sunk almost without trace. All that remains of the former Regional Planning Branch is the section (RCP2B) dealing with the theoretical side of the NHS planning system, which has now been absorbed into the policy planning unit and renamed PPU4. The central analy-

tical team has been disbanded without even producing a report on the 1978-9 round of strategic planning for general consumption within the NHS. The civil servants most closely associated with the development of planning in the NHS have either retired or moved to jobs unrelated to planning.

Departmental committees sometimes disappear without even their members knowing that there will be no further meetings. The Standing Group on Planning may well be in this category in spite of its obvious use as a forum for discussing the simplification of the NHS planning system proposed in Patients First. It was announced in reply to a Parliamentary Question that the Standing Group on Planning will be disbanded when its work is completed, or by the end of 1981, which ever is the sooner. The same applies to the London Health Planning Consortium. During their first months in office the Conservatives purged government of many committees and semi-autonomous organisations. Well respected bodies like the National Development Group for the Mentally Handicapped were not spared when the new administration set about its task of cutting what it considered to be unnecessary bureaucracy. Furthermore, the DHSS planning system has been wound down. Last year (1979-80) it produced only factual and analysis papers without working out options for change.

All these developments reflect the new Government's intention to simplify planning. Planning is seen as a device for keeping track of developments in the NHS, and not as a system for promoting change. Such an attitude will encourage health authorities to relegate planning to a perfunctory exercise, instead of using it as a means of co-ordinating developments. The lead being given by the Secretary of State is shown by his interest in the possibility of establishing a management advisory group (40). Such a group would be an inspectorate in all but name, for it would have 'responsibility for monitoring the quality and efficiency of the ways in which health services are managed, and for advising on the development of services at district level' (41).

An inspectorate corresponds more closely than a planning system to Mr Jenkin's idea of an appropriate control mechanism for the NHS. An inspectorate and a planning system are not mutually exclusive, of course, for an inspectorate could help to secure the implementation of plans. On the other hand, an inspectorate is more likely to be concerned about the quality of existing services than about the unmet needs in the community or about underdeveloped alternatives that might be preferable to available services. There is a danger that separate parts of the DHSS will promote a simplified planning system and a management advisory group in such a way that people working in the NHS will find it difficult to reconcile the two, although they will want to because coherence is valued. What role in the management arrangements of the restructured service does the DHSS envisage for (a) a simplified planning system, and (b) a management advisory group? What will be their relative importance? The health circular HC(80)8 issued in July 1980 on structure and management provokes rather than answers these questions.

A management advisory group could take a number of forms. Some illustrations of existing inspectorates in other fields (education, police, probation and after care, and prison service) are

given by Pethybridge, administrator of the North Western RHA, in his paper advocating an independent monitoring body for the NHS. He claims this would have the advantage 'of relieving Central Government of the need to delve into trivia, and leave the various Agencies free to apply their efforts to more appropriate issues' (42). Patrick Jenkin has responded by encouraging the North Western RHA to set up an experimental monitoring service, to introduce when its restructuring arrangements are clear (43). Other experiments will be welcomed (44) although many initiatives can hardly be expected from the health authorities when they are burdened with a restructuring exercise, and when management costs are being squeezed yet again. In any case, the policy of extending inspectorate or advisory services is not yet developed sufficiently to remove the need for planning.

PART II

HEALTH SERVICE PLANS

3. The evolution of the NHS planning system

One of the stated objectives of the reorganisation of the NHS in 1974 was to introduce a more comprehensive and rational planning system. Such a system was not, however, defined overnight; it began with general principles which evolved into a set of procedures. Consideration tended to focus on the system to the detriment of examining methodology. Nonetheless, the NHS Planning System established a framework for planning.

The Official Principles of Planning

The 1972 Conservative White Paper (1) stressed the need for a 'sound management structure':

> In future there will be a clear line of responsibility for the whole NHS from the Secretary of State to the RHAs and through them to the AHAs with corresponding accountability from area to region to centre. (Paragraph 128)

'Planning' would enable 'the supervision of delegated authority':

> The first requirement for effective supervision is good planning, so that comprehensive plans, which take account of available resources, are prepared within the AHAs and are reviewed and approved by RHAs and in more summary form by the Department. If omissions can be spotted and put right at the planning stage, then there can be the maximum delegation of authority in the actual conduct of the job, and the need for much more detailed intervention later on can be avoided. Secondly, supervision entails the monitoring of performance to ensure that planned standards of service and efficiency are being achieved. Performance can be monitored in various ways: by the collection and analysis of regular statistical information, by specially commissioned reports and enquiries, by visiting and contacts between the staff of the Department and field authorities, by systematic visiting, inspection and advice such as are carried out by the Department's auditors or by the Hospital Advisory Service, and by the self-critical observation and analysis of practice by which the professions monitor their own work. Finally, supervision requires the follow-up of plans to ensure that agreed actions are being taken and to consider their effect. (Paragraph 132)
>
> In the reorganised service, there will be a more systematic and comprehensive planning process than now exists. The

> Department will annually prepare guidance on national policy objectives for AHAs and RHAs who will then draw up their plans for the development of their services to meet these objectives together with their own local priorities. It is intended to seek methods of obtaining improved information and more effective measurement of needs and of performance. Such measurement is exceptionally difficult in health care and better statistical indicators have to be devised. All authorities will need to seek ways of using this information more effectively to assess the real progress of the service in achieving its objectives and to identify opportunities and problems. The reorganisation of the Department will, as has been explained, provide for it to have closer and more regular contact than in the past with the health authorities, which should lead to a better mutual understanding of problems and objectives. The Department's function of general supervision will be mainly directed towards the activities of the regional health authorities, who will be expected to supervise the activities of the area health authorities in the same way. (Paragraph 133)

The White Paper conceived a hierarchical system of planning. Emphasis was placed on defining the 'system' for planning, but there was little mention about the methods by which 'good', 'systematic', and 'comprehensive' plans would be produced - except by acknowledging the difficulties: 'such measurement (of needs and performance) is exceptionally difficult in health care'. The assumption underlying the White Paper was that structural reform would resolve practical problems: 'the reorganisation of the Department will provide for it to have closer and more regular contact than in the past with the health authorities, which should lead to a better mutual understanding of problems and objectives'.

The White Paper also considered financial administration. The method of paying for the NHS with money raised by national taxation and voted by Parliament was to remain unaltered. The DHSS would allocate finance (revenue and capital) to Regional Health Authorities. Payments to contractors (GPs, dentists, pharmacists, and opticians) would be separately funded from a budget held by the Department and administered by Family Practitioner Committees at the Area level. The construction of plans and the allocation of finance was intended as an integral process:

> The allocation of funds by the regional authorities will be closely integrated with the planning processes so that plans are based realistically on the levels of funds likely to be made available. (Paragraph 153)

> The estimates produced as part of the planning process will be the framework for a budgeting system designed both to give overall control and to provide functional budgets which will help individual managers to exercise detailed control over resources and to assess cost-effectiveness of departments and services against any recommended standards. Financial monitoring will form an important part of the monitoring of performance so that RHAs and AHAs will be able to compare actual

> results with estimates and budgets. It will enable the Department to be satisfied that efficient financial control and management is maintained throughout all authorities, and that funds are used to the best advantage and in conformity with national policies. (Paragraph 159)

There was little to suggest that Keith Joseph was as committed as his predecessor, Richard Crossman, to redressing geographical imbalances. Redistribution of resources is a policy of more prominence with Labour rather than Conservative Governments, because of the Socialist belief in equality. (It is also worth noting that the traditional Socialist constituencies in the North stood to gain from financial redistribution at the expense of the Conservative constituencies in the South.)

Shortly after the White Paper, a report was published of a study commissioned by the Secretary of State to outline management arrangements for the reorganised NHS ('The Grey Book') (2). The study took as its basis the Conservative Government's Consultative Document on NHS reorganisation (3), which preceded the White Paper, and the work of the management consultants McKinsey and Co. who were retained as advisors to the Secretary of State. Though never formally adopted as Government policy, it was widely read and was probably influential in establishing the pattern of management in the reorganised Service.

The Grey Book indicated that planning was an 'important process for all administrative tiers':

> The need to decentralise local planning and operational responsibilities must be balanced against the need for national and Regional strategic direction and control over public funds. This will be achieved by means of a comprehensive and formal planning and monitoring process.

It was envisaged that Districts would produce a single master plan with a ten year forward look and specific proposals for the next four years. Thus at that stage the distinct physical separation of strategic and operational plans was not envisaged. The Grey Book emphasised the need for plans to be within expected revenue, capital and manpower resource availability. Rather ominously the Grey Book also referred to planning as setting out 'what needs to be done....to achieve longer term growth'. Planning might have been better received if a period of sustained growth had occurred.

The reorganisation Act was passed in 1973, and in the following year a Labour Government came to power a few weeks before the appointed day for the change-over to the new authorities, on 1st April 1974. It was too late to halt the reorganisation even if any fundamental changes had been desired. The new Secretary of State, Barbara Castle, did however publish a document (4) proposing changes in the constitution of the membership of health authorities and in the role of Community Health Councils which were put into effect in 1975. Thus, the 1974 reorganisation was launched with the principles envisaged in the 1972 White Paper, which were elaborated on in the Grey Book.

The Development of the Planning Process

A series of reorganisation circulars was issued by the DHSS. HRC (72)3 in June 1972 requested the establishment of Joint Liaison Committees (JLCs) at Regional and Area levels. The work of the JLCs was to include drawing together information for the new authorities on any plans in hand. HRC(73)3 reiterated the general principles embodied in the 1972 White Paper:

> The Secretary of State accepts in principle the proposal that a planning and monitoring system, closely linked to the system of financial estimates and budgetary control, shall be a principal means of achieving accountability between the statutory authorities from AHA to Secretary of State. He also agrees that the same system should be adopted by AHAs within each Area for determining objectives and monitoring performance in relation to plans. Accordingly, the main management control to be exercised by one level over another will be the preliminary allocation of resources and the setting of guidelines to the level below, followed by detailed review and approval of plans covering the whole range of services and monitoring of performance in relation to plans. To begin with the planning and monitoring system will need to be quite simple. Later it can be further developed as a means of determining objectives and monitoring performance - as research produces more reliable standards, information is improved and staff become more expert in the use of the system. (authors' emphasis)

The sentence emphasised constitutes a crucial refinement of those original principles. The separation of planning and financial allocation is suggested, with finance assuming a lead role.

HRC(73)8 in April 1973 described how the Department was developing the planning system:

> The planning system proposed in the report on management arrangements (The Grey Book) relates to the determination of broad policy and priorities, and their transition into forward plans for the use of resources. It will not be concerned with detailed planning of individual projects or developments, but only with determining their priority and timing and the resources to be allocated to them.
>
> The forward planning function can usefully be broken down between:-
>
> (i) the research, analytical and considerative processes which result in policy choices and long term aims, and
>
> (ii) the 'programming processes' which result in decisions (which may be firm or provisional depending on the timescale being considered) to put into effect specific courses of action within a definite timescale as a means of achieving the long term aims, and to allocate resources to them.

> The latter, which leads on to the preparation of financial estimates, budgets and operating targets, is the aspect which it is intended should be subject to annual revision and updating in a formal planning cycle. The former is a continuous process which cannot appropriately be fitted into an annual cycle, though an annual summary of long-term aims may be desirable as background to programming aims.

Two distinct phases were envisaged: one concerned with immediate decisions for the next year (the operational planning process), the other concerned with identifying longer term goals (the strategic planning process). Such distinctions cannot, however, be made with absolute clarity since health care problems do not conveniently fall into two such neat classes. HRC(73)8 went on to acknowledge that: 'some important conceptual and practical difficulties must be resolved before a system can be devised', but concluded that delay would be undesirable. The circular announced the establishment of an advisory group of senior officers from Local Health Authorities, Executive Councils and the Health Authorities. The Advisory Group endorsed the proposals which McKinsey and Co. had drafted. Those proposals were to be tested in selected shadow Districts and Areas, with a view to preparing general guidance in 1973-74. It was thought that two or three years might be required to implement the planning system. A general description of planning in the interim was outlined in the circular. Undoubtedly, too much was expected of the infant authorities, particularly in view of 'the important conceptual and practical difficulties' which had been acknowledged. In the event, not all Authorities and Districts joined in the early rounds of planning.

During 1974, the Service was left to get on with the task of reorganising itself, and further guidance on the nature of planning would clearly have been inappropriate at that time. In March 1975, a letter (DS85/75) was issued to Area and Regional Administrators under the signature of the Deputy Secretary of the Regional Group of the DHSS. In that letter, planning tasks for 1975-76 were reviewed following the statement to Parliament by Barbara Castle, then Secretary of State, on the need to review strategy for the NHS in the light of the Government's decision to slow down the growth of public expenditure. The letter advised Authorities that a draft guide to planning was soon to be issued for comment and that they would be asked to introduce the NHS planning system in April 1976. A consultative document on national priorities in health and personal social services was to be issued shortly.

DS85/75 also asked Authorities to begin prepartory work to enable the drafting of outline strategic plans. Authorities were asked to review existing plans for capital schemes and to prepare bids for new schemes in advance of preparing their strategic plans. The illogicality of making specific bids for capital schemes in the absence of a long term plan was accepted as inevitable for practical reasons (i.e. the annual capital budget was there to be spent). Authorities were requested to set up multidisciplinary planning teams (where these did not exist). The Regions were asked to issue provision strategic guidance to Areas by mid-September; and Areas, with the participation of DMTs and in consultation with CHCs, were requested to develop outline stra-

tegic plans by the end of November of the same year. Regions should then prepare their outline strategic plans for discussion with the Department by the end of December 1975. The timetable was impossibly tight. Not surprisingly, the response from within the NHS was minimal, and the planning tasks set in DS85/75 were referred to repeatedly by the DHSS in subsequent years.

In the event, the uncertainties about public expenditure prevented the publication of the consultative document on priorities until March 1976. The draft guide to planning was issued, as promised, in April 1975 though certain key chapters on strategic planning and Regional planning were absent. In May 1975, the DHSS formally established the Resource Allocation Working Party (RAWP) to consider and develop a more equitable method for allocating financial resources. The policy on resource distribution was being developed separately from policies for particular patient groups.

In March 1976, the consultative document Priorities for Health and Personal Social Services was issued (5). An attempt was made to set out national policies and as such the document marked a significant new step in planning. In the foreword, the Secretary of State, Barbara Castle, gave her view of the relationship between central government and the local operating authorities:

> One of the biggest challenges to effective democratic government is how to reconcile two potentially conflicting aims: central government must be able to establish and promote certain national priorities, while the local agencies of government should have the maximum scope for making their own local choices in the light of their local needs .... This document seeks to meet this challenge by turning planning into a co-operative enterprise: a process by which the guidelines from the centre are related to - and influenced by - the experience of those who have to apply them in local circumstances.

Despite that rhetoric, the linkage between the formulation of national policies, and planning and action within the NHS, has remained tenuous.

The consultative document first outlined the financial position which had delayed its publication. The previously forecast rate of growth in current expenditure on health during the years 1976-77 to 1979-80 had been reduced. The money available for capital schemes would be cut to fund the growth in current expenditure - 'putting people before buildings' as the Secretary of State dubbed the policy. Some emphasis was placed on primary care (3.7 percent average annual growth in expenditure) to enable people to remain in the community, thus (it was assumed) relieving the pressures on hospital and residential services. The document drew attention to the priority needs of the non-acute sectors (the mentally ill and handicapped, the elderly, and children). Overall rates of growth for different care groups were proposed (table 1). For the first time, the Department's 'programme budget' was presented - 'a crude method of costing policies based on past expenditure' - which purported to relate service policies to available finance for the NHS as a whole.

The fact that future decisions on the levels of public expenditure on health and personal social services are at best uncertain

Table 1
Overall Rates of Growth by Service Group as Out-Lined in the Consulative Document on Priorities

Service Groups (including personal social services)	Proposed annual percentage growth in expenditure in real terms
Elderly	3.2
Mentally Ill	1.8
Mentally Handicapped	2.8
Children	2.2
Acute Hospital Services	1.2
Hospital Maternity Services	-1.8

could not have been more obvious at that time. Given that position, the value or relevance of proposing national average rates of growth in expenditure must be called into question, particularly since such simple averages masked substantial geographical variations in the provision of most services within the NHS (6). It is necessary that there should be a debate about national policies; it is also important that the operating authorities should have some background against which to frame local policies and plans. But the central question is: by what process could the range of overall targets with differing timescales be achieved? In practice, no such process existed.

In June 1976 the NHS planning manual (7) was issued by the Regional Planning Division of the DHSS under the cover of a Department circular HC(76)30, concurrently with the issue of the planning guidelines for that year contained in HC(76)29. The manual was similar to the draft guide issued the previous year, though the absent chapters were at last included. The planning system could be delayed no longer. The publication of the consultative document on priorities prompted the need to be seen to be doing something to implement those policies.

The planning manual established the framework of the system, the shape of which had already become apparent. Two kinds of plans were envisaged. Operational plans produced annually covering a 3-year period would include specific proposals for change. These would be produced against the backcloth of longer term policies established in strategic plans produced every fourth year, covering a 10-year period, though kept under continuous review. The Regional and Area Health Authorities would undertake strategic planning, and Areas and Districts would be concerned with operational planning. The linkage between different administrative levels would be the issue of annual guidelines to the level immediately below, and subsequently by the review and acceptance of the plans produced. The operational plans were not formally submitted

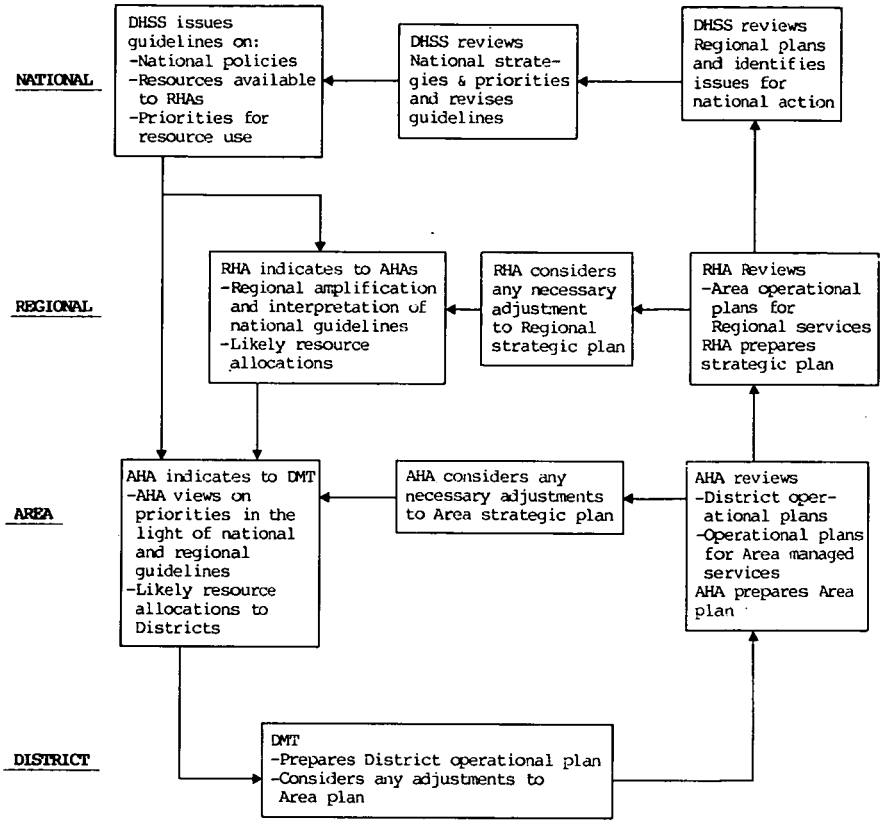


Figure 1. The Flow of Guidelines and Plans in the NHS

From The NHS Planning System

to the Department. Instead, each Region was required to submit an annual planning report about operational planning within the Region. The inadequacy of the first tentative round of strategic planning, and the less than unanimous response of Areas and Districts to the early rounds of operational planning, prevented the preparation of annual planning reports until 1978.

An inevitable problem surrounding the introduction of the system would always be the way of breaking into the interacting cycles of strategic and operational planning. The derivation of strategic plans would inevitably take a number of years; but whilst the operational plans might be produced more quickly, to take short-term decisions in the absence of a longer term sense of direction would deny the professed logic of the planning system. Inevitably, also, the necessary expertise and the information base would take time to establish, though the absence of much real effort

aimed at upgrading either of these suggests they were not recognised as being that important. (It has been a feature of planning in the NHS that those involved in producing plans have received little or no real training for the task. This has been reflected in the general quality of planning). All this activity was to occur at a time of cut-backs in management costs. Despite the problems, Authorities and Districts were asked to begin operational planning in 1976-77.

The flow of guidelines and plans is shown in Figure 1. Theoretically, this pattern represented a logical system of interpreting and refining national policies leading to the production of plans which themselves provide an input into further policy considerations. But such a simplified outline masked considerable practical and conceptual difficulties. National policies produced by the DHSS were of such a generalised nature that they were of little immediate relevance to the operating authorities, especially to Districts which were beginning with sets of services which differed significantly from the national average or from the levels of services elsewhere.

An additional complexity of the whole process was the requirement for formal consultation on all plans. Districts would have to consult with CHCs, Local Authorities, District Medical Committees (and probably with individual 'divisions'), and with staff interests; Areas would need to consult with CHCs, Local Authorities, FPCs, University Liaison Committees (in Teaching Areas), professional advisory committees, and staff interest; Regions would have to consult professional advisory committees, and the Univerity Liaison Committees. In addition to the formal consultation, any proposals involving change on any scale would require extensive informal discussions and negotiations with interested parties, as well as discussions between officer teams and with authority members. A proposal to close or 'change the use' of a hospital had to be consulted on separately. This could give rise to the strange position of the plan being accepted, but individual elements being rejected.

The logistics of undertaking and dealing with such wide consultation should not be under-estimated. On occaisions, more time was spent issuing plans for formal consultation and dealing with the inevitably wide-ranging comments which ensued, than was spent in analysing options and preparing the planning proposals themselves. Inevitably too, such wide formal consultation produced friction with those bodies whose comments did not produce the change requested. Reconciling differing professional advice and comments, which in turn differed from administrative imperatives (such as keeping within cash limits), placed impossible demands on drafting skills. It should not be surprising to observe that the text of documents produced under such circumstances was often anodyne, sometimes seeming to conceal rather than highlight the major issues and problems. Nevertheless, the proposals for formal consultation were a bold attempt to open up the planning process to wide public scrutiny.

Figure 2 indicates the prescribed operational planning timetable, showing the interplay between the different tiers. In practice, however, the timetable was seldom adhered to. The DHSS guidelines were usually issued about two months after the date

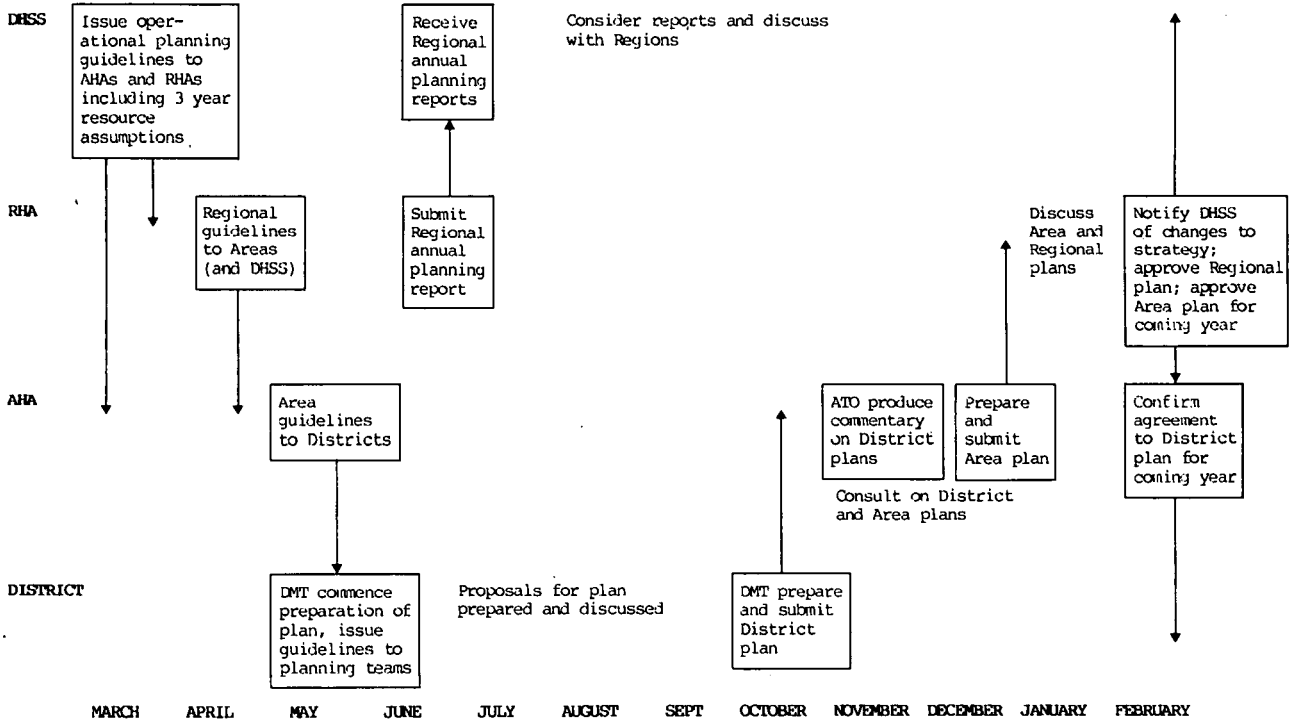


Figure 2. The Operational Planning Timetable

From: The NHS Planning System

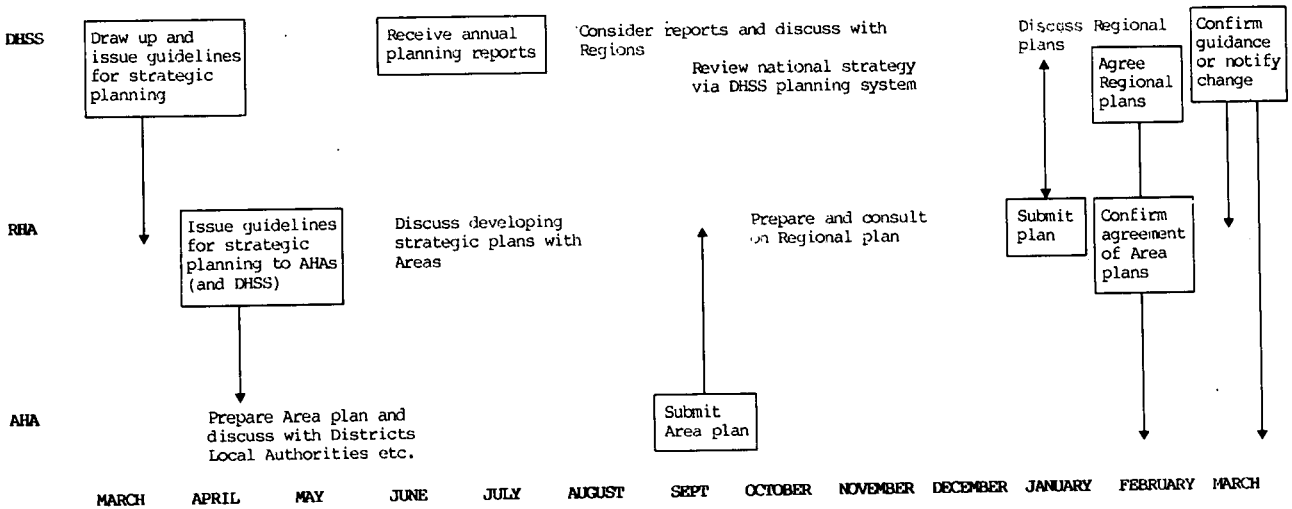


Figure 3. The Strategic Planning Timetable

From The NHS Planning System

indicated. Thus, Regional guidelines were equally delayed to Areas, as were Area guidelines to Districts. The Districts had the difficult task of producing plans (and consulting on them) during the summer holiday period. The timetable did not allow time for consultation at the Area level (typically 2 to 3 months might be required), nor for printing Area (or District) plans - a not inconsiderable task when often as many as one thousand copies of plans might be required. Once the Area plans arrived at the Region, the timetable was equally constrained, with much of the Regional activity falling somewhat inconveniently at the Christmas period. For all practical purposes, the timetable could not be achieved. It was not unknown for Areas to issue their guidelines before the Regional guidelines were received, and for Regions to issue their guidelines in advance of receiving the DHSS guidelines. And similarly, some Regions have produced their plans in the absence of all the constituent Area plans, and Areas in turn have completed their plans in the absence of all District plans.

The strategic planning timetable (Figure 3) proved even more unrealistic. The practice of producing strategic plans has been so diverse that no identifiable timetable is discernible. To expect anything but a rudimentary exercise within the timescale originally envisaged indicates naivity about what was involved. If, however, the four-year strategic planning cycle had ever been allowed to complete one cycle, then it is possible that the development of strategic plans and the refinement of particular policies would have evolved as a continuous process with the formal re-drafting every fourth year being merely a statement of the position as it had then evolved - though it seems unlikely that all authorities would have sustained the necessary effort implied over the intervening four years.

A key question left largely unexplored in the planning manual was the relationship between planning in the NHS and planning in the Department. The formal interface (the issue of guidelines and the consideration of Regional plans and annual planning reports) looked tenuous, given the generalised and turgid nature of the national policy statements.

The planning manual also gave an outline of the content required for both operational and strategic plans. For operational plans the use of a set of standard forms was proposed (GEN1/2/3 and H1/2/3) upon which changes in services and their resource implications should be shown. The aggregate consequences of the individual proposals contained on GEN forms would be summarised in terms of revenue, capital and manpower on forms H1, H2 and H3 respectively. Attempts to define a set of standard data for planning, the so-called information profiles, were somewhat shortlived; in practice few authorities attempted the tedious task of completing the profiles more than once, and some made no attempt at all. With hindsight, and with the benefit of the evidence of a major research project commissioned by the DHSS (8), it is clear that the simple re-hashing of routine data into information profiles fell considerably short of what was needed for realistic planning. No standard format for strategic plans was proposed at that stage.

The DHSS planning guidelines for 1976-77 (HC(76)29) were issued at about the same time as the planning manual in June 1976. Regions and Areas were instructed to complete the review of exist-

ing services and plans, and to prepare strategic plans for the period from 1977-78, the two tasks requested for the previous year in DS85/75. Areas and Districts were instructed to prepare 3-year operational plans for the period 1977-78 to 1979-80, and to establish joint planning arrangements with Local Authorities (the joint planning and funding initiative is considered later in this chapter). The consultative document on priorities issued in March 1976 was intended as the background against which planning should be undertaken.

One purpose of the national planning guidelines is to advise on the availability of financial resources (capital and revenue). Because of the way in which the public expenditure mechanism works, firm statements cannot be made about levels of resources during the planning period; instead 'assumptions' which are 'for planning purposes only' are put forward. In times of inflation, changes in economic policies, or even changes of Government (factors which have been dominant during the short life of the NHS planning system), the cash limits ultimately set can differ substantially from the assumptions upon which plans were based. It would be naive to suppose that forward planning in the NHS can ever be divorced from the general financial or political climate, and the resultant uncertainties. But the effects of those factors can produce changes which are neither planned nor part of any comprehensive assessment, and thus it would be equally naive to plan under the illusion that such factors do not exist. Actual cash limits, as opposed to planning assumptions, are usually announced to Regions shortly before the beginning of the financial year for which they apply. It is not exceptional for a District to have entered a financial year before knowing what its cash limit for that year is to be. It is difficult, given changes in the price base and the inherent assumptions about inflation, to relate actual cash limits to the resource assumptions used when plans for that year were conceived. The planning system and the methods used were unable to cope with, or even acknowledge, such uncertainty. Plans were often based on only one option inadequately assessed in terms of resources susceptible to change. Thus, there could be no certainty which proposals contained in a plan would eventually be realised.

The 1976-77 guidelines advised Regions that in preparing revenue assumptions for Areas:

> RHAs must aim to identify and progressively to redress existing inequalities between Areas. This process, which should be carried through to AHAs in the allocations to their Districts, should be based on the principles of resource distribution recommended by the Resource Allocation Working Party (RAWP) .... Areas and Districts which receive restricted allocations will need to conduct a particularly searching review of their services, so that those services which are relatively well-provided with facilities and staff can yield resources to those which are under-developed.

The guidelines announced that capital planning assumptions to Regions were based on the principles recommended by the Resource Allocation Working Party. Capital guidelines from Regions to Areas should 'similarly be aimed at redressing inequalities'.

Those guidelines elaborated specifically upon the developing relationship between financial allocation mechanisms and general service planning. As has been noted, the 1972 White Paper envisaged the setting of financial allocations and general service planning as an integral process, though official guidance at that time refined that principle by suggesting that the allocation of finance was the primary consideration. The promulgation of methods for establishing financial allocations which used criteria distinct from those used for general planning confirmed the separation of the two processes. The evidence of the various practices adopted by Regions clearly indicates that different sets of criteria have in fact been used for determining financial allocations and for establishing the levels of provision of different services in strategic plans.

A recurrent theme touched on in DHSS guidelines was the need to redeploy resources from 'well-provided' to 'under-developed' services. Such a simple statement masks the considerable practical problem of redirecting resources, particularly when the resources might not be directly transferable (say from the acute hospital sector to community psychiatric services). Inevitably too, the timescale of any such changes is protracted as services are run down and new services developed. But the official guidelines suggested the redeployment of resources as if it were merely a matter of changing entries in a financial ledger incurring no extra cost.

The NHS planning system was thus launched, though the start seemed inauspicious; the urgency attached to the need to begin planning was variable, and some Districts (and Areas) did not enter into the first round of operational planning. (One year later, by the end of 1977, only 76 out of 90 Areas had completed operational plans).

On 27th January 1977, the then Secretary of State, David Ennals, delivered his 'Better Value for Money' speech at the London School of Hygiene and Tropical Medicine which touched on some topical planning problems. He began by stating that 'it is not true to say that the NHS is bankrupt or on the verge of collapse', and provided statistics to show the scale of resources devoted to the NHS and how these had increased over recent years:

> Between 1973 and 1975 we have devoted an extra one percent of a roughly static gross national product to health care - mainly, and I make no apology for this, on improved pay for those working in the Service.

This statement might be contrasted with the assumptions about 'demography' and 'improving medical techniques' used to plan public expenditure.

> The bulk of this extra money has gone on the hospitals which over the last five years have increased their share from about 60 percent to nearly 65 percent of the total current expenditure. We are better equipped than ever before and better staffed.

This latter statement reflected one of the very real problems of

planning; how to prevent the acute hospital sector from increasing its share of the total expenditure at the expense of other priority services.

> Despite the economic crisis, the Government will be increasing current resources for the health services over the coming years but at a slower rate. We are feeling the effect of the economic climate. The national growth rate set out in the (Public Expenditure) White Paper last February of about one and a half percent per annum still stands. Nationally we are not cutting the health service - only the planned rate of growth. Though the Government is providing a year by year increase in funds, it can do little more than provide for the increasing number of elderly people leaving a very small margin for improvements in methods of treatment. But the room for growth is minimal. In order to alleviate the poorest Regions in the country, those that have been historically better provided for are feeling the pinch.

The statement that the planned increase in funds can 'do little more than provide for the increasing number of elderly people leaving a very small margin for improvements in methods of treatment' reflects the basis of the argument put forward by the DHSS to the Public Expenditure Survey Committee (PESC) which seems to be accepted repeatedly without challenge. It consists of two elements: first, an assessment of the growth required to ensure that levels of expenditure per capita can be maintained when allowance is made for demographic changes (particularly the increasing numbers of elderly); second, an allowance for increasing sophistication in medical technology which it is assumed will cost more. It is important to note that there is no direct linkage between the assumptions which form the basis for the amount of money voted by Parliament, and how in fact the money is spent.

The Secretary of State went on to emphasise the problems of geographic inequalities, particularly in relation to London:

> The special problems of London have not been caused by cuts in the health service budget. They result from the historic concentration of health provision in the capital, movement of the population and the widely accepted need for a fairer geographical distribution of resources in a National Health Service.
>
> The reorganised National Health Service has now made it possible to make somewhat of a belated change.

If that analysis sounded ominous for the Thames Regions, then some comfort could be found in the ensuing caveats which suggested that the redistribution process would be achieved by under-provided Regions 'catching up', and that it was necessary to allow for the implications of clinical teaching and 'centres of excellence'. Those latter two factors have presented thorny problems which the Thames Regions (and others) have found difficult to grasp.

The speech also drew attention to the need to achieve a better balance between different services within a fixed total pool of

resources. The priorities embodied in the Consultative Document were stressed. Emphasis was given to services for the mentally handicapped, the mentally ill, the elderly, primary care, and prevention, balanced by restrictions in the acute and maternity sectors of the hospital service. To achieve better value for money, it was asserted that more efforts were required to improve the efficiency and effectiveness of services - two fundamental issues which lack practical translation.

The DHSS planning guidelines for 1977-78 (HC(77)19) were issued in May 1977. Again, attention was drawn to the priorities document and to the Value for Money speech by the Secretary of State. For the third time, Regions and Areas were asked to complete the reviews requested in DS85/75 and to continue work on strategic plans. Following the introduction of operational planning, Regions were asked to submit annual planning reports to the Department. Areas and Districts were asked to begin the next round of operational planning, and to continue the work on joint planning with Local Authorities. For its part, the DHSS set itself the task:

> To examine Regional Strategic Plans to assess whether they: take adequate account of national policies and priorities; are practicable within revenue, manpower, capital and other constraints; produce an acceptable national strategy; require revision of national policies and priorities; and, provide scope for further progress in local and national planning methods and information.

In the light of those tasks, the circular indicated that the DHSS would consult health authorities and publish revised policy guidance on priorities. The guidelines also included financial assumptions for the planning period, though they were couched in terms which suggested even more uncertainty than in the previous year. It was requested that the finance be distributed following broadly the same principles advanced previously. Attention was also drawn to 'the need for compatibility of financial, service and manpower plans and projections' and to the relevance of manpower planning generally, though with the exception of general guidance on consultant posts in certain specialties, little by way of practical methodology for manpower planning was advanced.

In September 1977, The Way Forward (9) continued the debate on national policies and priorities started by the Consultative Document eighteen months before. The priorities previously put forward were again endorsed, though some of the practical problems which had emerged during the period of consultation were acknowledged. For example, particular difficulties were evident for geriatric hospital provision (it has been proposed that half the geriatric bed provision should be located in the District General Hospital complex). Evidence from the Regional strategic plans indicated that this was too ambitious. It might be necessary first to devote resources to the acute hospital sector to rationalise provision there before other problems could be tackled. The Way Forward argued that despite the formidable difficulties the problems were urgent and tackling them could not be postponed.

A crucial question left unanswered concerned the relationship between national policies and what was planned (or in fact happened) in the Service. Indeed, the dilemma was highlighted:

> A revised national programme budget analysis has been prepared taking account of the 1976 based population projections, differences between the 1975/76 out-turn and the 1975/76 Consultative Document estimate, and revised assumptions for unit costs. These projections have been translated into implied levels of provision which represent broad national objectives. They are not specific targets to be achieved by declared dates, even at national aggregate level. The 1979/80 projections are intended only to illustrate what might be achieved given provisional resource constraints. The projections are not based on any detailed information about intentions of authorities nor do they take account of the most recent work connected with the rate support grant on personal social services, which suggests that social work and home help services are likely to grow less than the projections envisage. (Paragraph 3.12)

Such a tentative statement seems to be a far cry from the more forceful principles embodied in Keith Joseph's 1972 White Paper, and it is tempting to wonder to what purpose such national projections might be put.

Emphasis was placed on the NHS planning system:

> For the NHS, a planning system has been in operation since April 1976. It takes account of the different functions of different levels of the service, and distinguishes between strategic planning and shorter term operational planning. There must be a real commitment at all levels to planning as a systematic approach to identifying needs, considering priorities, devising realistic ways of implementing those priorities and consulting and involving those whose interests are affected. (Paragraph 3.15)

It was stated that Regional strategic plans were tentative and incomplete; they would be revised for submission in January 1979. An appendix of the document devoted one and a half pages to summarising the main points emerging from those plans and indicating a number of practical shortcomings in their content particularly with regard to manpower planning and planning methodology (the relationship between Regional and Area plans, and strategic and operational plans; and the need to relate proposals to the availability of resources).

In December 1977, a health notice (HN(77)185) was issued announcing the establishment of a 'DHSS/NHS Standing Group on NHS Planning'. The terms of reference of the group were:

> To act as a channel of communication between the NHS and the Department on planning matters, including methods, information needs and procedures.
>
> To identify problems requiring new and revised guidance on planning matters, to commission studies of these problems and to advise the Department on the guidance which should be issued.

Clearly some such initiative was required given the very different nature of the first attempts at planning and the real difficulty

the Department must have had trying to interpret the plans it received.

In January 1978, a letter to Regional and Area Administrators from R.S. King, then under-secretary in the Regional Group of the DHSS, asked Regions and Areas to continue work on strategic planning. The Standing Group on Planning had devised a set of 'minimum core' tables which should be included with a strategic plan. A standardised content for strategic plans had also been devised which included six 'Summary Analysis of Strategic Plans' (SASP) tables, and which was intended as an addendum to the planning manual. It was acknowledged that the Standing Group had not had the opportunity to undertake a fundamental review, because of the need to issue early guidance (the group had then been in existence only 3 months which suggests that the proposed format was produced within the DHSS and then merely endorsed). But a certain amount of cynicism on the part of those involved with planning in the NHS was justified in view of what was proposed. For example, the statement in the covering letter that: 'considerable flexibility has been built in, particularly in the choice of alternative approaches to revenue costing and in the extent of detail in medical manpower planning' might have been more accurately interpreted as meaning that no credible methodology could be proposed for costing plans or manpower planning - two key areas of any strategic plan, as emphasised in The Way Forward. The guidance did little to resolve any of the major conceptual or practical difficulties of planning; it might best be described as an attempt to ensure that the coverage and content of plans was reasonably complete, and that the resulting plans would be compatible and comparable. Revised plans, in accordance with the new guidance on format and content, were requested for 1st January 1979.

The DHSS planning guidelines for 1978-79 (HC(78)12) issued in March 1978 were more extensive than in previous years because of the request to produce strategic plans in that year. Much of the content was more appropriate for long-term planning than relevant to what could be incorporated in a 3-year operational plan. It included not only guidance to health authorities but covered also Local Authority personal social services. Guidelines specific to individual Regions were dispatched separately. The tone of the guidance was forceful, indicating strong commitment to national priorities. The guidelines considered the individual priorities in turn, adding emphasis or elaboration where necessary. Forceful the content might have been, but it still failed to bridge the gap between national exhortations on the one hand, and the practical problems of planning in the NHS on the other. For example, the financial guidance was as uncertain as ever and was based on the usual assumptions (demography plus improving, more costly, medical techniques). Such assumptions may not correspond with what has been planned (c.f. the statement in The Way Forward that the development of services for the elderly might have to wait while the acute sector was redeveloped), or to how the money would in fact be allocated or moreover spent:

> These guidelines rest, as regards the years to 1981-82 on the financial assumptions in the White Paper on Expenditure, which provides for some margin of development, over and above

> that needed to cover the effects of demographic change, and to make some allowance for the cost of constantly improving medical techniques. Projections are given ... illustrating a possible national distribution of expenditure and level of service provision in 1981-82 consistent with these financial assumptions and compatible with Ministers' priorities. These illustrative figures are not targets, but signposts indicating the direction of change to be pursued through the strategic planning decade. They are not specific targets for national developments, still less local targets to be aimed at by particular authorities regardless of local circumstances or of the baselines from which they start. The projections illustrate national averages which may reflect wide local variations in patterns of expenditure or provision of services. (Paragraph 1.4)

Guidance on other issues, whilst referring to real problems seemed to be naive in its perception of what authorities could do, or of the depth of the problem being referred to. For example, on primary care:

> RHA strategic plans have drawn attention to the importance of associating family practitioner services more closely with NHS planning .... Revised strategic plans should include a strategy for improving primary health care; they should discuss manpower levels and distribution, accommodation and organisation problems, such as grouping, formation of teams, deputising arrangements, health centres, group practice centres and alternative bases for community nurses.

A basic feature of the reorganised NHS was the continued independence of the family practitioner. Where the primary care problems appear worst, in inner cities particularly London, such independence is characterised by very strong attitudes against change of the kind suggested in the guidelines. Though the problem is real, the suggested approach falls some distance short of what is required.

On acute hospital services, the guidelines pointed to another real problem - that some Districts and Areas were placing undue emphasis on providing all services within their administrative boundaries - but the proposed solution failed to tackle adequately the important issues. It was stated:

> In the discussions with health authorities on RHA strategic plans, the Department has made clear that the objective of making local provision for comprehensive health care (i.e. hospital and community health services) does not necessarily imply that AHAs and Health Districts should aim at total self-sufficiency in the normal range of hospital specialties within their administrative boundaries, but rather at equality of opportunity of access to services, including the full basic service of a well developed DGH or DGH complex. Planners must distinguish between cross boundary flows of patients which are 'natural' in a geographical sense and acceptable, and those which are distorted by present imbalan-

> ces in the location of specialist services which their strategic planning must set out to correct. In assessing future populations for planning purposes, health authorities should adequately discount those elements in present (or traditional) referral patterns and patient flows that are distortions caused by present inequalities of hospital provision. (authors' emphasis)

Concepts such as 'equality of opportunity of access' are of obvious importance, but knowledge is lacking; basic research rather than exhortation is required. To distinguish objectively between 'natural' patient flows and those which are distorted by services imbalances, is not a practical proposition. Discounting present or traditional referral patterns moves close to encroaching upon clinical freedom - or more likely, in referring patients, doctors will ignore the assumptions of planners.

Other guidelines seemed to be out of place alongside such substantial problems:

> Health authorities should plan expansion of low vision aid services with a revenue expenditure increase nationally of £0.5m by 1981-82. (Paragraph 2.19)

The process by which policy documents are refined through the Departmental planning machinery probably leads to such inclusions; each policy branch seeks to get its area of concern mentioned.

The guidelines also mentioned policy under consideration within the Department, though in the event not all the work materialised (e.g. the White Paper on the elderly promised for spring 1979 had not been produced eighteen months later). The programme budget was again presented with the qualifications that it was for illustrative purposes only, and not intended as targets or even maxima or minima to be achieved. General manpower planning guidance was included, with more particular assumptions for medical manpower. Because of the dual function of the guidelines, for strategic and operational planning, both long and short-term financial planning assumptions were included.

Those guidelines provided the background to the first full round of strategic planning requested for January 1979 using the format designed under the aegis of the Standing Group on Planning. By January 1979, less than a quarter of the Regions had produced the plans requested (and even a year later four plans had still not been completed).

On 5 January 1979, the Secretary of State, David Ennals, announced the cash limits for Regional Health Authorities for 1979-80. The cash limits had been determined in accordance with the targets calculated using the RAWP methodology. It had been found that the most 'under-provided' Region (North Western RHA) was then currently 12.02 percent below target, and the most 'over-provided' (N.W. Thames RHA) was 12.1 percent above target. By giving the former 3 percent growth and latter 1 percent growth, the positions would be transformed to 8.76 below target and 12.98 above target respectively. As the Secretary of State put it:

> These allocations mean that in a few short years this Government will have made a real impact on a major social injustice

> - the long-standing imbalance between the relatively poor health facilities in the North of England and the much better off Southern part of the country.

On priorities it was stated:

> All the wealthier Regions have to respond to demographic change but they also have Areas which are as deprived as those to be found in the poorer Regions. And even in their well provided Areas, little development has yet been possible in the Cinderella services - community health, mental illness and mental handicap services and services for the elderly. To make progress on both these fronts in accord with national policies, these Regions need and will receive an extra margin for growth. But I must make clear to those Regions my intention that they should deploy the increase they receive to their deprived Areas while at the same time pressing their well provided Areas to develop their priority services by a process of rationalisation and redeployment of resources available to them. I shall look for the clearest justification for any departure from this programme.

It is possible that this statement was referring to certain inner-London authorities whose problems were surfacing on the political scene or to the content of the first attempts at strategic planning. Again the dilemma of the constitutional responsibility of the Secretary of State versus the considerable practical autonomy of the operating authorities was evident. Though national policies had been published, no real mechanism for implementing them existed, and with finance being allocated en bloc, the only leverage which the Department might exert has not been exploited. The earmarking of funds, which the Secretary of State's statement comes close to suggesting, is anathema to NHS officers - and also to DHSS and Treasury civil servants who would be bound to monitor how the money was in fact spent, and perhaps have to respond to difficult parliamentary questions. When funds have been earmarked (albeit on a small scale), the restricted use of such money has often led to underspending.

In March 1979, a report was sent to Regional and Area Administrators again under the signature of R.S. King which summarised the development of planning between 1976 and 1978, concentrating on the first tentative round of strategic planning. It was claimed that 'the health service does appear to be coming through the initial and most difficult phase'. The document went on to reiterate the familiar national priorities. But the messages emerging from the first Regional plans indicated a considerable tempering of national policies in practice. For acute services, the problems of pursuing plans for self-sufficiency were evident. On primary care services and prevention, the national policies seemed to have been accepted but actual progress was absent, not in the least because the responsibility for these services is diffuse and a co-ordinated policy is difficult to implement. Policy for the elderly had been questioned on the grounds of the practicability of locating 50 percent of geriatric beds in the DGH complex, and whether Local Authorities could provide the necessary levels of

complementary services. Progress for the younger physically handicapped, the mentally ill, and the mentally handicapped seemed to be slow or non-existent against a background of substantial local variations. Little coverage on children's services was included in plans. The over-provision of resources in the maternity sector seemed to have been accepted, but Regions were cautious in attempting reductions. The reluctance to cut maternity services probably resulted from uncertainties about future birth rates, and the fact that the maternity sector has a clear measure of outcome (perinatal mortality); no plans to cut services could fly in the face of the inevitable claim that 'babies will die'. Overall, the first attempts at strategic planning showed that the movement towards the identified national policies was restrained.

The DHSS planning guidelines for 1979-80 issued in April 1979 followed the familiar pattern. Resource assumptions for operational planning were included as usual, but with modifications (as a result of the pressures and forces being exerted on the political plane) for the Thames Regions. The Secretary of State's intention for those Regions was that:

> (a) as far as possible increased resources should be deployed in favour of deprived Areas in these Regions;
>
> (b) within, broadly, the resources currently available to them, the relatively well provided AHAs in these Regions should continue the process of rationalising services, and redeploy resources to the development of their priority services...; while;
>
> (c) the RHAs should continue to redeploy further resources in favour of their deprived Areas as judged practical and appropriate.
>
> The balance to be struck from year to year will depend on the resources available and on progress achieved in rationalising services in London. The change of emphasis giving priority to the development in London of services for the elderly, the mentally handicapped and the mentally ill and community health services rather than to the movement of resources from London to other areas may be expected to affect the distribution of resources within and between areas in the operational planning period. But it is not, of itself, seen by the Secretary of State as having significant implications for longer term strategic planning.

That statement represented some success for the inner-London Teaching Areas which had begun planning under considerable pressure to reduce services. Powerful forces had been mobilised to offset that threat, not least being the pressure by local (Labour) MPs at a time when the Labour Government was in a minority in the House of Commons. The redistribution of resources geographically as well as to the priority groups depended on the resolution of the problems of inner-London, given a constrained budget for the NHS for the forseeable future.

In May 1979, a further addition to the NHS planning manual was

published from the Standing Group on Planning. It was in three parts: first, modifications suggested in the content of Regional Annual Planning Reports based on experiences on producing them; second, suggestions for appraising proposals for major capital developments (then defined as costing over £2.5 million) including the novel notion for the NHS of discounting future costs to the present so as to enable the comparison of different options; third, detailed considerations relevant when major schemes were being commissioned. The document contributed to the process of learning from practical experience and represented a useful addition to the devoloping planning system. It was, however, too late for the round of strategic planning initiated in 1978.

Planning in the 1980s?

During 1979 the Regional strategic plans were completed one by one. Following the general election in May that year, it seemed from the statements of the new Secretary of State, Patrick Jenkin, that the end of an epoch for planning, if not for the NHS itself, was beginning.

It is clear already that the report of the Royal Commission on the NHS (10) published two months later in July 1979 provided little more than a minor diversion. Given the Commission's political conception, the election of a Conservative Government made it likely that its recommendations would carry little weight. Yet the work of a Royal Commission cannot be dismissed too lightly.

The report touched on a number of issues relating to planning. Most important was the tenuous link in the DHSS between the promotion of policies and the allocation of finance. The commissioners said:

> We agree with the Expenditure Committee that: 'the expenditure planning and priority setting of the DHSS should be synchronised so as to enable Parliament to examine the relationship between the two'; but even after listening to careful explanation by representatives of the DHSS about the way in which the needs of particular priority groups are taken into account in the allocation of resources to health authorities, we remain mystified. (paragraph 6.17),(authors' emphasis)

It is hardly surprising that the Commissioners should feel mystified, for the plain fact is that the allocation and distribution of finance is an exercise conducted quite separately from the setting of priorities or general planning. The Commissioners also commented on the inadequacies of financial management and budgetary procedures within the NHS, but did little more than recommend that the report prepared by Perrin (11), which was published separately, be read by the operating authorities.

Several months after the publication of the Royal Commission's findings, the Conservative Government's proposals for the NHS were issued for consultation in a short document titled Patients First (12). In no real sense was this a response to the many recommendations of the Royal Commission; rather it was an affirmation of

principles held long before the general election (13). The kernel of what was proposed was summarised as:

> a) the strengthening of management arrangements at the local level with greater delegation of responsibility to those in the hospital and in the community services;
>
> b) simplification of the structure of the Service in England, by the removal of the area tier in most of the country and the establishment of district health authorities;
>
> c) simplification of the professional advisory machinery so that the views of clinical doctors, nurses and of the other professionals will be better heard by the health authorities;
>
> d) simplification of the planning system in a way which will ensure that regional plans are fully sensitive to district needs. (Paragraph 7)

To those ends, the main specific change proposed was the abolition of one tier of administration - the Area level. The general drift of the argument was to return more authority to the District level, and especially to the hospital. This proposal constituted the main substance of the Conservative Government's policy for the NHS issued subsequently in July 1980 (HC(80)8).

Despite the problems of planning primary care services, it was proposed that the administration of the Family Practitioner Services should not be altered. The Government's policy subsequently confirmed that the Family Practitioner Committees would continue to function on an Area basis and thus would not correspond geographically with the new District Authorities. Such an administrative structure cannot facilitate the integrated planning of primary care with other health services; experience suggests that integration was lacking under the old structure even when the links between FPCs and Area Health Authorities were more direct. When Patrick Jenkin stated in the House of Commons that: 'the 1974 reorganisation represented a major step forward in the integration of hospital and community health services including primary care', the statement was greeted with derision (14).

The proposal in Patients First to have the Regional Health Authority members in the main comprised of District Health Authority chairmen could weaken the ability of the Region to take an independent view away from the heat of local political argument and prejudices. No mention of the composition of RHAs was made when the Government's policy was published in July 1980. There was, however, a statement that:

> As to the long term, the Government is clear that there will remain an important regional role...

But, having listed the Regions' tasks, this apparently clear statement was qualified:

> The Government intends in due course to review the relationship between RHAs and DHAs (under which DHAs exercise their

> functions by delegation and are accountable to RHAs) and the composition and functions of RHAs and the role of the Department in relation to them and with a view to enhancing local autonomy. (HC(80)8/LAC(80)3 paragraph 39)

There must, therefore, be some uncertainty about the planning role of Regions and about what pattern of administrative practice will emerge.

As yet, there has been little mention of the role of the DHSS and its relationship with the NHS, nor any mention of the national planning and financial processes, except for a vague statement in Patients First that there should be 'the minimum of interference by any central authority'.

A commitment has been given to planning, though with the qualification that the system will be simplified:

> The discipline of planning in both the Department and the NHS has demonstrated its value and is to be retained. It provides the opportunity for the Government's policies and priorities to be reconciled with available resources. It also enables health authorities to appraise systematically their own services and to influence Government. But existing planning arrangements are over-complicated and bureaucratic. A simpler planning system is being worked out and will be discussed with the Service. (Patients First, paragraph 36)

It is not clear what evidence (if any) formed the basis for these judgements on the value of Departmental and NHS planning. The Department's Central Analytical Team had been disbanded before its assessment of the last round of strategic planning was complete. No Departmental analysis of those plans has yet been published. Three research projects into the workings of the NHS planning system in a handful of selected authorities were commissioned by the Department (15); their findings have been submitted but not widely published.

It is not yet clear what form the simplified planning system will take, though an unpublished document (16) gives some indications. It appears that the main features might be:

a) Strategic Plans which will be prepared by the District Health Authorities within a framework produced by Regions; the Region will prepare a 'Regional Overview';

b) Annual Programmes which will replace operational plans;

c) Planning Review Meetings which will be held at all levels;

d) Annual Planning Reports from Regions will no longer be required.

Notwithstanding certain minor changes (e.g. strategic plans will be re-written every fifth year rather than every fourth year), the general out-line of the proposed new system is broadly similar to the one it replaces, though with changes of emphasis in the roles of the different levels of authority. The 1980-81 guidelines

(HC(80)9) confirmed that the Department does not want to see regional annual planning reports or operational planning guidelines. The lack of concern with the detail of NHS planning is consistent with government policy to reduce the level of central involvement in NHS management.

Despite a commitment to collaboration between health and personal social services, there is as yet no mention of what form of administrative machinery might be developed following the demise of the Area tier. The Government intends that Joint Consultative Committees will continue to cover one or more Districts within a Local Authority area, but that:

> The exact arrangements for formal and informal links should should be determined by the DHAs and the local authorities concerned. (HC(80)8/LAC(80)3)

In the field of collaboration, two particular initiatives are relevant. Joint Planning and Funding was introduced by the DHSS, and involves collaboration between health and personal social services. The Inner City Partnerships were launched by the Department of the Environment and involve a wider spectrum of public services. Both schemes require the practical co-operation of different local agencies, with different planning systems, and with fundamentally different styles of working. Though both initiatives were small in terms of the levels of expenditure in relation to the spending of the separate agencies, they are worthy of note since they represent two attempts to establish formal links between complementary services which are administered separately.

Joint Planning and Funding

The proposals from both political parties leading up to the reorganisation in 1974 continued the administrative separation of health and personal social services, the former being administered by the health authorities comprising the NHS, the latter being administered by Local Government Authorities. Yet all proposals were unanimous on the need to achieve effective collaboration for planning and operational purposes, and to this end the boundaries of Areas were drawn to be co-terminous with particular levels of Local Government.

A Working Party on Collaboration was established by Keith Joseph, then Secretary of State for Social Services, to examine the inter-relationship between health and personal social services. A reorganisation circular, issued in July 1973 (HRC(73)17), referring to the Working Party's report (17), gave guidance to shadow health and local authorities about the arrangements necessary to bring about co-ordination. Joint Consultative Committees (JCCs) at Area Health Authority level should be established 'to advise their parent bodies on collaborative activities and on the planning and operation of services of common concern'. Other recommendations included that: local authorities should co-opt AHA members of officers to their committees; local authorities should appoint nominees of AHAs as part-time 'proper officers' for environmental health functions; both authorities should collect

and publish information on joint working, and that JCCs should set up intelligence teams to provide information; joint working parties should be established to ensure the best use of services and equipment; the JCCs should provide a focal point for the co-ordination and provision of training activities. A study commissioned by the Nuffield Provincial Hospitals Trust (18) has examined the mechanisms for collaboration and has concluded that, with the exception of the proper officer duties for environmental health, those recommendations have been implemented 'minimally or not at all'.

There were logistical problems concerning the establishment of JCCs. In England and Wales, 98 AHAs had to relate to 411 local authorities. The most straightforward case existed when a single-District Area was co-terminous with one local authority responsible for education, social services, housing and environmental health. For the majority of cases, however, the position was more complex. In large non-metropolitan counties an Area with as many as six Health Districts may have to relate to one County Council, and up to 14 District Councils. In London, co-terminosity between Areas and Local Authorities responsible for personal social services (London Boroughs) did not exist, and education was the responsibility of yet another agency (the Inner London Education Authority). It is not surprising that it took three years from 1973 to negotiate suitable arrangements in all Areas, and that wide differences in working practice were evident.

A circular was issued in March 1976 (HC(76)13/LAC(76)6) for consultation concerning joint planning arrangements for joint funding. The circular stated:

> There is already a statutory obligation on health and Local Authorities (Section 10 of the NHS Reorganisation Act, 1973) to co-operate in the exercise of their respective functions. Joint Consultative Committees (JCCs) were established in 1974 to advise Area Health Authorities (AHAs) and their matching LAs on their performance in co-operative activities and on the planning and operation of services of common concern.

It seems that the DHSS was ignorant of the practical difficulties.

The circular went on to propose the establishment of Joint Care Planning Teams (JCPTs) comprising officers from both health and local authorities, which would formulate plans and proposals for the consideration of the JCCs. Starting in 1976-77 a special allocation within the total public expenditure allocation for health would be made available to fund schemes which were approved by the JCC and the separate authorities, and which fulfilled the general criterion that:

> the health authority accepts that the recommended project justifies the use of NHS resources in terms presribed and can be expected to make a better contribution in terms of care than would deployment of equivalent resources directly on health services, (HC(76)13, appendix 1).

Joint financing monies would meet the full capital costs of approved schemes as well as the revenue costs for 5-7 years after

which the local authority would meet the running costs. Thus, for local authorities, joint financing offered the incentive of capital funding at zero cost (in the NHS, capital costs are met directly from Exchequer monies and are written off immediately, local authorities must gain loan sanction approval to borrow capital with resulting interest charges). But a serious disincentive for local authorities was the burden of meeting the running costs after seven years. The financial outlook for local authority spending caused this to be a dominant consideration.

The origins of the notion of joint financing are not clear. Banks, an Assistant Secretary in the Regional Group of the DHSS during the introduction of the joint funding arrangements and the NHS Planning System, suggests that the reason might have been pragmatic - to buy the Department into local authority planning (19). She states:

> In 1975 it emerged that the policy of changing the pattern of care for the elderly, mentally ill and handicapped required a substantial shift of funds to personal social services, and also to health capital. Both these shifts were made in the 1975 survey. There is, however, a major problem in that there is no guarantee that money switched from the health service to local authorities will eventually find its way into the personal social services. For this reason the DHSS provided an expanding amount of 'joint finance' funds, which are allocated to health authorities for them to spend on local authority social service projects, providing support for people who might otherwise have to be cared for in hospital. This, as has been observed elsewhere, in effect creates a specific grant to local authorities for limited purposes.

In practice, the level of finance has been relatively small (originally £16 million intended to rise to £40 million by 1980).

The 1976 circular was replaced in May 1977 (HC(77)17). In general, the content was similar, though there were additional proposals which indicates that the Department had perceived the need to tie joint planning and financing into the NHS planning system. The circular stressed the need to take a 'strategic approach' in order to enable the production of guidelines 'for officers in health districts and local authorities who were responsible for drawing up shorter-term operational plans'.

> ... the time tabling of LA/AHA joint planning should be designed, as effectively as possible, to enable the two authorities to feed the results into their separate planning processes.

The assumptions about the workings of the NHS (or local authority) planning system cannot have been based on any evidence. Despite that guidance, joint planning generally continued to function independently of the planning system.

The circular proposed the establishment of District Planning Teams (DPTs). From their proposed constitution DPTs were almost identical to the existing Health Care Planning Team (HCPTs). The proposal to establish DPTs had a confused reception: in some cases existing HCPTs were suspended; in some cases they continued under

a new name; in some cases they were re-formed, and no doubt in other cases nothing happened.

The joint funding mechanism was restated. Subsequently, in October 1979 (HC(79)18/LAC(79)11) the arrangement for transferring the revenue burden to the local authority after 5 or 7 years was modified to the extent that in exceptional circumstances, and with the approval of the Secretary of State, support from joint funds could be extended beyond a 7 year period. Paradoxically, joint financing budgets have often been underspent; local authorities have been reluctant to commit themselves to additional revenue expenditure in the future.

In general, the response to joint planning seems to have been poor. Examples of outstanding initiatives seem to have resulted mainly from persistent individual action; the formal machinery appears to have contributed little. But premature judgements may be unwise; the administrative machinery was inevitably complex, and the ideas and relationships needed time to evolve. Nevertheless, the need for effective collaboration remains pressing. The abolition of the Area tier could destroy the basis upon which joint planning and policy making might have evolved. Without coterminous boundaries, the resulting administrative problems inherent in joint planning might prove to be insurmountable.

Inner City Partnerships

The establishment of the Inner City Partnerships by the Department of the Environment was intended to enable different agencies to take joint action to reverse the general decline of the inner-cities. Forsyth and Varley (20) have traced the background and history of the seven Inner City Partnerships (Birmingham, Liverpool, Manchester and Salford, Gateshead and Newcastle, Hackney and Islington, Lambeth, and Docklands) established during 1977 (21). They were established to 'give the inner areas an explicit priority in social and economic policy'. Financial aid was given to the partnership areas to stimulate co-ordinated policy and action between public agencies and private industry. Health authorities were junior partners in the process.

The partnerships were launched at a time when health authorities were beginning to implement the NHS planning system and at a time when no health authority had yet produced its strategic plan. At relatively short notice, agencies with different administrative and planning processes were called upon to plan jointly. At that time also, the RAWP philosophy was being implemented which identified those health authorities within the partnership areas as being overfunded (because of historical population decline). Health authorities within partnership areas have been able to use partnership funds to offset the effects of DHSS policies to redistribute resources according to RAWP principles. Forsyth and Varley point to the procedural confusion both in terms of the administration of the financial programmes and in the failure of the different agencies to appreciate each others policies. The criteria used to allocate partnership funds for health schemes have conflicted with the general priorities of health authorities. Yet despite this, health authorities have felt obliged to grab whatever finance was available.

4. Planning theory and practice

General Concepts

The NHS was launched on the principle that services should be available to all persons requiring them, in the main free of direct charge. DHSS guidance post-1974 restated that principle as meaning that health authorities should plan to provide 'equality of opportunity of access' for persons in need. The planning manual (1) elaborated further:

> ...planning must be responsive to .... the needs of people
>
> ...planning must be flexible enough to meet the changing patterns of need
>
> ...all the real problems and needs of people, regardless of the presence or absence of public pressure
>
> ...(the purpose of planning) is to relate services as closely as possible to people's needs by the best use of the available resources

General principles such as these raise complex conceptual problems which have to be answered (or avoided) when decisions are taken to provide specific levels of service. At any one time the range of possible answers will be conditioned by the current pattern of services and by established practice.

A first logical step in planning should be the consideration of what constitutes need. On general grounds, needs will vary between individuals with different characteristics, and individuals with the same needs will differ in their perception and desire to seek treatment or care. The planning manual distinguishes real needs as being important for planning purposes; perhaps more relevant are perceived needs (real or otherwise) since it is these which are translated into demands for services, and the two forms of need may not be identical. To be of practical value for planning purposes such abstract concepts of individual need have to be applied to populations of given sizes and characteristics to determine the pattern of demands which may be made at some future time. If this knowledge existed, it would then be necessary to determine how best to meet given patterns of demand. Alternative courses of action with different resource implications, and possibly with different outcomes and levels of effectiveness might be open. For some demands no course of action may be open. Given finite resources, treating certain demands precludes treating others, which

implies that some way of adjudicating between the competing claims on resources is required. In a rational world, a pattern of services would be chosen which achieved the maximum benefit for a given total of resources (including, perhaps, social costs and personal costs to patients and their dependents as well as exchequer monies).

Having identified a desirable pattern of services, logistical and organisational problems of providing buildings and equipment and training staff have then to be resolved. A first step is to assess existing services and facilities to judge to what extent they contribute to the desired pattern. This may involve the consideration of intangible as well as tangible factors; for example, there is inevitably some reaction against whatever change is proposed. Such considerations might indicate a number of reasons why the desired pattern of services cannot be achieved in the period envisaged; for example, because the resource implications are too large, or the scale of change can not physically be achieved. If this should be the case then the basic assumptions will need to be refined to achieve a feasible plan. This suggests that planning should be an iterative process of reconciling ideal requirements with what is feasible, but undertaken in a way such that conscious decisions are taken, the implications of which are evaluated.

To take rationality to its conclusion, the breadth of consideration would need to be widened, across the spectrum of public welfare services. Health and social welfare problems do not neatly fall within the currently defined areas of responsibility of the different statutory agencies, rather they transcend bureaucratic boundaries. If the argument (2) is accepted that the main determinants of health are environment, nutrition and behaviour, then the implication is that resources should be channelled into policies intended to influence these factors in the first instance.

A policy for prevention of disease and promotion of good health presents further conceptual problems since by definition this involves taking some form of action for which there is no immediate demand, and hence consuming resources which otherwise might be used to meet immediate needs. And, since the range of preventive measures lies in the main outside the currently defined domain of responsibility of the NHS, this could imply taking resources from the NHS for the use of other services. In a rational world, attempts would be made to quantify the possible future benefits from spending different levels of resources on preventive programmes. Future benefits would need to be 'discounted' (since presumably a benefit realised now is more desirable than a possible future benefit of equal magnitude). The option of spending resources on preventive measures would then be assessed against competing claims to allow a decision on which services and to what extent resources are to be used. Rationality to this extent seems far off.

Even if such a rational approach were desirable, it is clear that the necessary fundamental knowledge is lacking on most fronts. In the NHS, empirical data can be used to assess current demands on particular services (though in some instances, for example in the general area of primary care, basic data of this sort are often lacking), but data on the range of services used by

particular types of demand are not generally available. There is no way of knowing the extent to which the existing pattern of services affects perceptions of need and hence influences demands. It is practically impossible to measure the outcome of different forms of treatment in all but a few instances; unequivocal measures are difficult to define with the exception of death. The need to assess the effectiveness of different forms of treatment is widely argued and acknowledged (3), but to undertake rigorous statistical trials of all alternative forms of treatment and care is unlikely ever to be a practical proposition. An objective method of resolving competing claims on resources is probably beyond definition. Major difficulties are even evident with attempting to assess the logistical consequences of meeting different patterns of demands. Fundamental issues such as these may only be resolved over time as gaps in knowledge are filled and experience from developing rational planning methods is gained. Even then, some problems may prove to be intractable.

Notwithstanding such fundamental issues, it is necessary to consider the methods currently used to construct plans if lessons are to be learned and progress made. Within the framework of the NHS Planning System, Regional strategic planning occupies an important part.

A practical starting point for all strategic planning in the health service must be the definition of the population for which services are to be provided. Administrative boundaries have little relevance in determining where individuals are referred or seek care, or in determining what form of service is required. In this respect the defined statutory responsiblity of the Area to provide the range of basic services for a community, and the role of the District as the basic operational unit, were somewhat ambigious. In early attempts at planning this led to a preoccupation with planning for District self-sufficiency (i.e. all the services for the residents of a District physically located within its boundaries). The resource consequences would probably have been impossible to satisfy even if such an approach were desirable. The DHSS brought this to the attention of the NHS authorities, though the ambiguity was not resolved when the DHSS requested Regions to distinguish 'natural' patient flows between administrative boundaries from those caused by the historical location of health facilities, without any operational definition of such an abstract concept.

Different definitions of populations might be expected in terms of the level (to Region, Area or District), or in terms of the way in which population flows between different administrative boundaries might be accounted for. In addition, depending on the anticipated incidence of different classes of demand, different approaches to defining populations for planning purposes may be necessary for different services. When deriving a strategic plan for the next ten years the scale of change possible within that period may be less than that ideally required. Thus, populations for planning purposes may reflect practical limits as well as ideal goals.

The next step is to assess the needs of defined populations, the demands which will be made, and the way in which these might be met. This essential aspect of planning is the one least under-

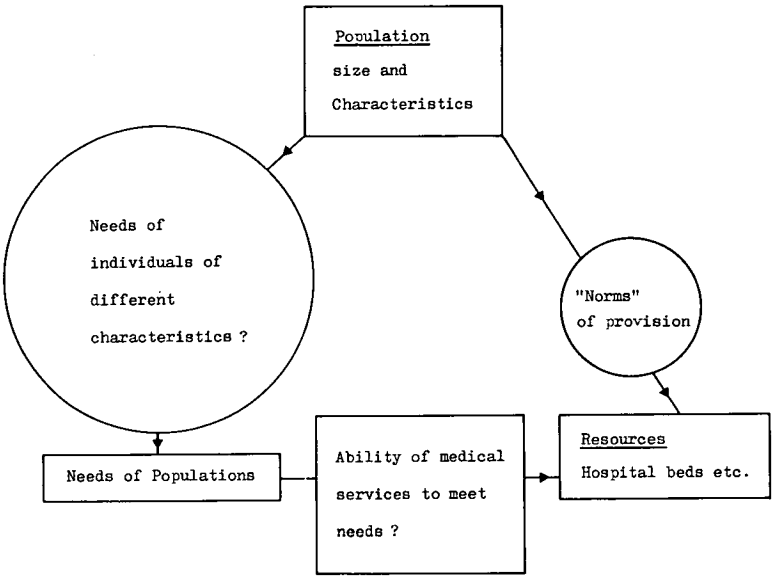


Figure 1. Two Approaches to Deciding Levels of Services

(From Ashford, J.R., 'Planning Local Health Services' in Framework and Design for Planning, Nuffield Provincial Hospitals Trust, 1977.)

stood, and the one where gaps in fundamental knowledge are widest. For practical purposes such questions have to be left unanswered and an alternative, though less satisfactory, procedure adopted. Ashford (4) delineates the two alternative approaches, which are reproduced in figure 1.

The use of norms of provision, based largely on existing definitions and patterns of service, moves directly from statements on population to statements on the level of resources to be provided. Issues such as efficacy, effectiveness, or outcome are avoided. The normative approach is attractively simple, requiring only the multiplication of two factors - a rate of provision or 'norm' (eg. 2.5 beds per 1000 population) and the population size. Different norms are used for different services (e.g. acute beds, day places for the elderly, etc.). Such an approach avoids difficult conceptual issues, and does not place impossible demands on available knowledge or information, nor too much stress on the analytical capabilities of planners. The convenience of the normative method cannot, however, be matched by any guarantee that the results obtained will approximate those which might be derived from a more rigorous analysis.

The use of norms has the practical advantage of avoiding the problem of adjudicating between different needs competing for the same resources. Though this problem might be disregarded at the

strategic planning stage, when operational plans are formed and decisions taken on how to spend the next year's cash allocation, the need to consider competing claims on resources is brought back sharply into focus. Such belated priority setting may, however, call into question the feasibility of the strategic plan. The normative approach is one which most Regions have adopted.

The normative method defines the levels of major resources; other complimentary resources have also to be defined. Manpower is a prime resource in the NHS (nearly one million people are employed), and though it may be a resource less amenable to planning than others, clearly any strategic plan must incorporate a manpower plan consistent with its basic goals if it is to have any pretentions to feasibility. Yet manpower planning in the NHS is poorly developed; traditionally emphasis is placed on medical manpower which constitutes numerically but a small part of the total workforce, though attempts in this direction seem to have been less than a complete success (5).

Another prime influence and constraint on planning is the likely availability of financial resources. This is subject to an inherent measure of uncertainty given the nature of the public expenditure process; the financial guidance from the DHSS to Regions issued for strategic planning purposes in 1978 was framed in this light. Clearly, an important practical test of any Regional plan is whether it is financially feasible, a test which has two parts: revenue and capital. The planning manual cautions unwary planners: 'to be on their guard against unrealistic resource assumptions'. There are, however, no accepted means by which the revenue consequence of strategic plans might be evaluated. Existing costing data are expressed in terms which are not suited to the demands placed on them for planning purposes (6). Capital consequences are related to particular schemes, but the necessary depth of appraisal, or even the identification of all major and minor schemes, is unlikely to be a practical proposition at the strategic planning stage. Such technical studies may each take upwards of a year to undertake and the necessary expertise is in short supply. The NHS convention which does not cost capital expenditure (which may be contrasted with the procedure in other public sectors which requires the repayment of interest charges on loans for capital schemes, and the normal practices of financing in the private sector) is likely to distort the real perspective concerning the use of financial resources in their totality.

The planning manual defined planning as:

> deciding how the future pattern of activities should differ from the present, identifying the changes necessary to accomplish this, and specifying how these changes should be brought about.

And defining a strategy was described as:

> deciding how to move the organisation from where it is now to its agreed objectives.

Such statements clearly indicate that strategic planning should be concerned with evaluating what practically can be achieved and

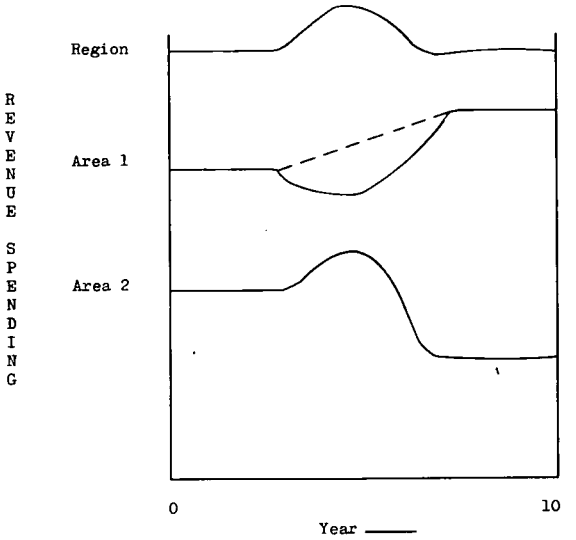


Figure 2. Revenue Spending Profiles for a Hypothetical Region with Two Areas

determining how the envisaged change might be brought about. A plan is only useful if it can be shown to be capable of being achieved. In this respect the important major aspects of a strategic plan will need to be evaluated, as opposed to the finer detail which can be considered through the annual operational planning process.

The design of the strategic planning system gave weight to assessing the ten year end-point of the plan. An intermediate three year point (the horizon of operational planning) was also included in the design of SASP forms, but that point was often in practice no more than an interpolation between the two ends rather than an assessment of what should have been achieved by that time. Despite the stated intentions concerning 'identifying changes . . . specifying how these changes should be brought about', and 'deciding how to move the organisation', little emphasis was given to evaluating revenue or capital spending profiles year by year during the strategic planning period. Such profiles are unlikely to be uniform and may, at District or Area level, be highly irregular. This could create serious problems which cast doubt on the practicality of the plan.

Consider for example the hypothetical Region with two Areas shown in figure 2. The Region wishes to pursue a policy of geographic redistribution of revenue from Area 2 to Area 1 within a constant Regional allocation. To achieve reductions in Area 2 it is necessary to reduce services by a process of rationalisation which involves building a new hospital to enable the closure of

several smaller units. Whilst the new hospital is being commissioned and the smaller units closed, the period of overlap results in additional revenue expenditure. Given the constant Regional budget, the implication is that under-funded Area 1 would have to endure financial cut-backs to allow over-funded Area 2 to spend more during the overlap period. In practice, it would not be possible to reduce an under-funded Area to provide resources for an over-funded Area. The alternative is for the Region to overspend its cash limit. An even less desirable (though more likely) alternative is that the new hospital in Area 2 will be built but no funds will be available to open it. This may happen in Regions which have embarked on major capital developments but have yet to evaluate the consequences in sufficient detail.

It follows, therefore, that policies for distributing financial resources sub-Regionally should be an integral part of the general strategy which Regions are pursuing. Yet, we observe that Regions are generally using RAWP-type formula to determine the basis for setting allocations to Areas and Districts which use different criteria from those used to set levels of services in their strategic plans. There are signs, however, that some Regions are beginning to appreciate the need to integrate planning and resource allocation (7). In the absence of such integration, there can be no guarantee of the financial feasibility of any plan. The separation of financial allocation from general planning in the NHS and the DHSS represents muddled thinking. If there is a thrust to redistribute finance geographically then it should be part of a comprehensive strategy to redistribute services, not simply an end in itself.

These general considerations point to areas in which the methods adopted by different Regions might be compared and assessed, to construct a picture of the practice of planning in the NHS. These are:

- the definitions of populations;
- the classification of services, identification of 'need', and determination of levels of provision;
- the assessment of resource consequences;
- the validation of the plan and assessment of feasibility.

Practice as Opposed to Theory

Before descending into the detail of particular plans it is necessary to recognise that the practice of decision making may be far removed from theories of rational planning.

At Regional and Area levels the work of service planning was usually delegated to a multi-disciplinary team of second-in-line officers which formulated planning proposals and recommendations for the consideration of its chief officer team. Typically, the planning team consisted of an administrator, a finance officer, a nurse, and a community physician, and other officers would be con-

sulted as required (e.g. for technical advice a works officer might be called upon). A variety of different sources of advice and guidance were available; for example: the plans and guidelines of other tiers; the advice of the various professional advisory groups; the recommendations of officers charged with managing specific services (e.g. dental officer, scientific officer). Because decisions taken in one tier invariably affect other tiers, a delicate balance in working relationships between planning teams and chief officer teams in different levels had to be maintained. An inevitable source of frustration and delay stemmed from the fact that planning teams could not take executive decisions; rather they made recommendations to their chief officers who in turn may have needed to refer matters to their respective health authorities or through the professional advisory machinery, a referral process which may often have taken several months to reach a conclusion.

At District level (envisaged at reorganisation as the basic planning unit) it was intended that initial planning proposals would be created by Health Care Planning Teams (HCPTs). Such teams would be established for particular care groups (e.g. the elderly, children) and would include representatives of the different professions providing the respective services. The number or constitution of HCPTs was never established in official guidance; rather the position was left open, with Area Authorities and Districts given the power to establish HCPTs as and when required. Not surprisingly in the absence of any clear administrative protocol a measure of confusion ensued. The establishment and the role of HCPTs has varied between Districts. If HCPTs were allowed to work in an unconstrained manner without appropriate guidance from District Management Teams (particularly on financial constraints), then inevitably this caused frustration and a lack of interest when the proposals produced were not acted upon. On occasions, proposals from HCPTs have been allowed into District operational plans (on GEN forms) yet have not featured in that section of the plan (the H forms) summarising resource consequences of planned intentions. This indicates the confusion within the DMT which was faced with the need to produce a plan within resource constraints yet which received batches of proposals for additional resources from the HCPTs. Subsequently, with the introduction of the joint planning and financing arrangements in 1976/77, guidance from the DHSS indicated that District Planning Teams (DPTs) should be established to assist in the task of operational planning. This guidance created further confusion since the role and composition proposed for the DPTs seemed almost identical to the previous HCPTs (and the latter were not even mentioned in the circulars: HC(76)18, HC(77)17). Not surprisingly, the response to that guidance seems to have been mixed; new teams seem to have been created, often HCPTs were renamed, often nothing seems to have resulted.

At District level the views of the medical profession were in theory strongly represented. Two members of the DMT were a consultant and general practitioner. The District Medical Committee representing hospital consultant and general practitioner interests constituted a powerful voice presenting advice or comment on District plans. Any significant proposal for change affecting ser-

vices would have to be considered by the appropriate Cogwheel division. In practice, the professional advisory machinery appears to have been more effective in commenting on the proposals produced from within the administrative (including community medicine) framework rather than creating new ideas.

A number of attempts have been made to categorise the practical behaviour of decision-makers and planners and the way this affects the nature of the decisions taken. In a study concerned with the definition of the information requirements of planning (6), an extensive survey of the literature revealed four categories of models which might be used to describe the practical nature of planning in the NHS. These are termed: the rational comprehensive model; the disjointed incrementalism model; the mixed scanning model; and the political model.

The rational comprehensive model requires a clear statement of objectives and goals. Alternative ways of achieving goals are analysed comprehensively. The way which can be said to be the best (usually in terms of excess benefits over costs) is chosen as the course of action to be adopted. The principles underlying the design of the NHS planning system, and strategic planning in particular, conform to this stereotype. The rational comprehensive model may be challenged on the grounds that existing knowledge does not permit the exhaustive examination of all possible alternatives in a rigorous fashion, and that the decision maker is not a purist seeking to optimise but a pragmatist seeking a satisfactory solution. It is argued that the choice between conflicting goals is likely to be subjective, depending on the achievement of an effective consensus amongst those involved in taking decisions.

From these considerations the disjointed incrementalism (or 'muddling through') model had been postulated as a means of describing the decision making process. It incorporates a conservative approach proposing that agreement on a course of action is dominant over the rigorous analysis of the effects of alternatives, and that consideration is confined to marginal rather than fundamental issues. Restricted analysis enables the post hoc rationalisation of objectives to the policies which have been pursued.

The mixed scanning model postulates a cross between the rational and disjointed incrementalism models. According to this model, an over-view is taken of fundamental issues but within this incremental decisions are taken. Depending on the nature of external forces, decisions will vary between the extremes of being fundamental or incremental (e.g. in times of stability, incremental decisions will be taken).

The political model concentrates on who takes the decisions. It is postulated that decisions result from bargaining between different individuals or pressure groups with different powers and vested interests. Accordingly, policy is the resultant of the various forces exerted from different points of view and with different strengths rather than the consequence of objective analysis.

Clearly no one model can hope to explain the NHS planning process which itself has been evolving over time and is subject to different interpretations based on the perceptions and viewpoints of different observers. To some extent, the four models over-lap

and they might be used in conjunction to provide an insight into the different practices at different administrative levels.

The evidence on planning prepared for the Royal Commission (8) ranged over a spectrum of issues in one Region and one of its Areas and Districts. The Region (N.E. Thames) and the Area (City and East London AHA(T)) chosen might have been expected to reveal certain biases because of the particular problems in the Thames Regions and the inner-London teaching Areas. The design of the NHS planning system followed the rational model, but with certain in-built contradictions concerning consultation and the participation of pressure groups and vested interests. It was stated:

> Participation and consultation are thus seen as the centrifugal forces which challenge the rational basis of planning.

Interviews with officers revealed different perceptions of planning. Not surprisingly emphasis shifted from the DHSS through Region and Area to District. The rational approach was more prominent in the DHSS and at Region, whereas the District was more concerned with the political problems of effecting change.

The existence of different perspectives at different administrative levels is of fundamental importance to the planning system. The higher levels of the planning hierarchy (the DHSS and the Region) are concerned with broader policy, whereas the District is the basic operational planning unit which develops specific proposals for change and is responsible for implementing them. The forces evident at the District level, particularly those resulting from the interface with clinical autonomy and local political pressures, are fundamentally different from those at Regional and Departmental levels. This may be a desirable feature of the planning system. When difficult decisions implying changes in policy have to be taken, it is necessary to consider them away from the reactionary forces which will be powerful at the local levels. But if analysis reveals that fundamental changes in policy are required, then the problem of effecting the change still remains. It seems likely, therefore, that the Government's decision to abolish the Area, and distance the Region and the Department, will widen the gulf between national policies and local action.

From time to time a number of initiatives have been launched by the Department which have upset the gradient of rational at the centre to political at the periphery. The sums of money involved are normally small in relation to total expenditure but the way in which the money is ear-marked for particular kinds of scheme runs contrary to the block allocation of finance generally in the NHS, as well as conflicting with the philosophy of planning, which implies considering all competing claims on resources comprehensively before funds are devoted to a particular cause. For example, the following sums were earmarked:

Capital expenditure on health centres (1976 guidelines, 1976/77 prices)

£18m in 1977/78
£18m in 1978/79
£19m in 1979/80

Aids to the construction industry (1978 guidelines, 1978/79 prices)
£17.2m in 1979/80
Energy conservation (1978 guidelines, 1978/79 prices)
£6.5m in 1979/80
£3.2m in 1980/81
Renal dialysis and waiting lists (1978 budget)
£44m in 1978/79
Secure psychiatric units
£34m from 1976 to 1980

Rarely has any attempt been made to monitor how these various monies have in fact been spent. In April 1980 the Guardian reported that:

> Regional Health Authorities have now received £34 million since 1976 to fund secure psychiatric units, even though no such unit has yet been opened. The figure has been reached with a recent payment of more than £9 million from the DHSS ...Mr. Kilroy Silk (Labour MP for Ormskirk), who has raised the matter on several occasions, has condemned the inaction of the 14 Regional Health Authorities as 'a major public scandal'. Three authorities, NE Thames, South Western and Oxford had not spent any of the £6 million they had received on such units, he said.

Curiously, the present Conservative Government has also indulged in the same practice, a move which seems inconsistent with their drive away from centralisation and towards local autonomy in the health service. For example, the N.E. Thames RHA was prevented from closing the Elizabeth Garrett Anderson Hospital and money for hospital maintenance was reported to have been allocated from central funds; £100,000 was given to Papworth Hospital for heart transplants; Dr. Vaughan, the Minister of Health was reported to have announced some financial support for renal transplants at Dulwich.

Rational planning theories, and even taking decisions, is one thing; translating decisions into workable practice may be quite tional plan at Area or District level indicate some of the problems which were masked by the neatly constructed forms and timetables promulgated in the planning manual.

The theory required the construction of a comprehensive set of proposals evaluated in captial, revenue and manpower terms. The aggregate resource requirements of proposals were to be consistent with resource assumptions issued in guidelines. In practice, however, no accepted methods for evaluating proposals in such terms were available. The constraints of the planning timetable generally precluded detailed study, and often the use of crude averages was all that was possible. Yet figures quoted in plans often seemed to acquire a status unjustified by their pedigree, particularly in the eyes of those who had little knowledge of how the data had been derived. Proposed capital schemes, in particular, required extensive technical appraisal if anything approximating a reliable cost was to be produced. But the short timescale, and the uncertainty of whether the capital proposal would be accepted for funding, made detailed evaluation unlikely.

In practice, operational plans often tended to focus on bidding for capital schemes. Lists would be compiled by Districts and Areas sometimes only sparsely evaluated in capital, revenue or manpower terms. Such lists were prepared in priority order, though the ordering could only be notional in the absence of an objective method for adjudicating between competing schemes. The nature of the bidding process meant that there could be no certainty which bids would be accepted by the Region for funding. The stated priorities might have little influence. The bids produced tended to represent an over-commitment against likely available resources in the knowledge that not all proposals would be accepted for funding. Thus, there could be no certainty what the aggregate revenue and manpower consequences of the operational plan might be.

Once a capital proposal had been accepted, the detailed work of specifying the content of the development began in earnest to enable architects and engineers to produce technical specifications to enable its construction. This level of evaluation might reveal factors which were not known, and hence could not be accounted for, at the operational planning stage. The normal procedure of establishing project teams including those who would actually work with the new development often introduced aspirations which were outside the original intentions of the proposal. Without skillful handling such project teams could produce specifications with revenue and manpower consequences outside acceptable bounds. Yet project teams tended to focus on keeping capital costs within previously agreed levels at the expense of other resources. Thus, for example, the consideration of spending more capital money to achieve revenue savings seemed to be foreign to accepted working practices.

An important practical limitation on local planning was the considerable difficulty of reconciling service plans with financial budgets. The former would often be framed in terms of particular patient groups or capital developments with a measure of uncertainty because of the nature of the bidding process; the latter were usually set in functional terms (such as nursing, pathology) with an implied measure of precision over the financial year to which they applied. It was not exceptional for plans and budgets to be the responsibility of different disciplines whose work lacked proper integration.

In reality, the theory of compiling comprehensive plans evaluated in resource terms was difficult to translate into working practice. Such practical problems are inherent in any scheme of planning until basic knowledge and procedures are improved. The format of the NHS Planning System tended to gloss over such practicalities.

5. Strategic plans — the Thames Regions

In common with other large cities, inner-London has experienced a period of decline. The resident population has fallen substantially during the present century. The pattern of health service provision has not been correspondingly adjusted to reflect the population movements. Much of the existing hospital stock is in the form of old and decaying buildings becoming less suited to provision of modern medical services, though there have been some spectacular re-developments of famous old hospitals in the inner-London zone.

Planning in London is further complicated by the large concentration of teaching hospitals and so-called centres of excellence within the inner-London area. Many of these prestigious hospitals were founded in the eighteenth and nineteenth centuries, some much earlier. There are 12 undergraduate medical schools, 5 dental schools, 13 specialist post-graduate institutes, the Royal Post-graduate Medical School, and the London School of Hygiene and Tropical Medicine, which are all part of the University of London. About one-third of the doctors and dentists in Great Britain are trained in these schools. Any proposals for change are vigorously resisted by the medical profession, despite doubts whether sufficient numbers of patients exist within the catchment areas of teaching hospitals to provide enough material for teaching purposes.

Since 1974 the cost of undergraduate teaching hospitals has been met out of the annual budgets of teaching Areas and Districts. The identification of the additional costs of teaching (the Service Increment for Teaching) was one of the more contentious and doubtful elements of the RAWP analysis. The failure to provide for the full costs of teaching causes strains in teaching Areas and Districts, and creates the paradox that the general service provision for the residents of those authorities is penalised by the presence of so much specialised excellence which takes a disproportionate share of available resources (1).

London's health plans have been very much in the political arena as well as the public eye. The attempt by the City of East London AHA(T) and the N.E. Thames Region to close the London Jewish Hospital is an example. Both the Region, the Area and the Tower Hamlets District concurred that the hospital should close, it being surplus to requirements in one of the most over-resourced Districts (according to RAWP criteria) within the NHS and contributing about £1 million per annum to the Area's over-spending. But the intervention of the local jewish MP Ian Mikardo with the Secretary of State at a time when the Labour Government was in a minority in the House of Commons effectively delayed a decision on its closure (2).

The intransigence of the Lambeth, Southwark and Lewisham AHA(T) over cuts proposed by the S.E. Thames Region has caused problems which two successive Secretaries of State have failed to resolve. An article in New Society (3) highlighted the underlying causes of the conflict:

> Lambeth, Southwark and Lewisham has always refused to give up any of the £30 million a year above RAWP's assessment of its needs, even though the reduction requested by the region is very gradual - £1.8 million last year, £1.2 million this.
>
> The reason this AHA made a fuss is largely political. While Ted Knight, the leader of Lambeth council, heads the Labour fight against local authority cuts, Townsend orchestrates the health side. The underlying cause of the trouble, however, lies much more in the historical conservatism of the medical establishment than in the immediate political arena.
>
> The health service in this country has always been based on hospitals. Drawing money and services away from them is like working against a magnet. And teaching hospitals - centres of excellence - are the most powerful magnets. The Lambeth, Southwark and Lewisham area is divided into four districts, decided by the traditional catchment areas of the three teaching hospitals, with Lewisham district the bit left over. This division is a constant bone of contention with the local authorities who originally wanted the AHA to have boundaries coterminous with their own.
>
> The population of the districts has declined and changed in structure and, as the DHSS points out, the 'hospital facilities have not in any sense been adjusted correspondingly'. The level of acute hospital facilities in the area is far in excess of the regional and national average. But the area is deficient in services for the elderly, mentally ill and mentally handicapped, and its community health services are below the level required in an inner city area whose socio-economic infrastructure shows marked deprivation.
>
> Money is still divided between the four districts that make up the area on a historical basis, with little prospect of reallocation. The three teaching districts, with expensive buildings and large staffs, demand more each year, so that the gap between them and Lewisham widens. St. Thomas's and Lewisham districts both have a population of 190,000. Lewisham's budget is £21 million, Thomas's is £43 million.'

Other inner-London Teaching Areas face similar problems. The conflicts have arisen because in accordance with the DHSS instructions health authorities have attempted to implement RAWP, and to plan for priority services.

Each of the four Thames Regions, which cover London and neighbouring counties, has produced a strategic plan, though the approach and methods are notably different. The N.E. and S.E. Thames Regions attempted a comprehensive strategy based on a conventional population-norms approach (though using different definitions of populations and norms). The N.W. Thames did not produce a comprehensive plan, but concentrated on acute and geriatric ser-

vices. It appears that the S.W. Thames plan has been largely dominated by decisions taken on capital developments, though it is not clear on what basis those decisions were taken. The London Health Planning Consortium (LHPC), a DHSS initiatied working party, has also produced its own calculations of hospital in-patient bed requirements. Notwithstanding the particular problems of London, nor the different approaches used by the four Regions and the LHPC, we propose to examine their methods using the basis developed in the previous chapter.

Populations

For London there are two alternative sources of population data which are invariably used: the Office of Population Censuses and Surveys (OPCS), and the Greater London Council (GLC). The OPCS produces projections based on census data and known trends in fertility and death rates together with assumptions about future rates and patterns of migration. The GLC and County Councils in the Thames Regions produce forecasts which take account also of known factors (such as housing developments) which are thought likely to influence future population distributions. In general, GLC and County Council forecasts are higher than OPCS projections. They are also more detailed, covering Districts as well as Areas. The N.E. Thames plan explains why it chose GLC figures for London:

> (the OPCS projection) is produced nationally; is based on nationally assessed assumptions about fertility and migration, and takes no account of special factors which are believed to affect the population of London (for instance the Government's Inner-City Policy).
>
> The GLC forecasts ..... provide a more conservative set of assumptions than do those of the OPCS ..... it seems appropriate to use a less contentious set of figures.

It goes on to observe:

> The new (OPCS) projections estimate the Region's 1988 population to be some 3 percent lower than previous estimates used and each health authority projection is lower than previous estimates have shown it. A degree of questioning of - if not opposition to - these new figure may therefore be expected.

This statement indicates how sensitive an issue the question of population size has become and what impossible demands are being made on the data. No projection based on the 1971 census can reasonably claim to be within 3 percent accuracy when projected to 1988, particularly in London.

The N.W. Thames plan, in using GLC and County Council forecasts, includes a cautionary reminder:

> The degree of credibility that can be attached to population projections may be gauged by the fact that the 1974-based

national projection indicates an end of century Great Britain population almost 15 millions lower than was projected only nine years previously. A report on population by the Central Policy Review Staff states that '... projected population by the end of the century has varied between 50 and 72 million; the projection of live births at the end of the century has varied between 650,000 and 1,500,000 per annum. The variations have not been steadily in one direction but have oscillated wildly.'

Population projections by the GLC acknowledge their lack of precision and give a range of possibilties which for 1986 range between 1,954,000 and 1,762,000. Figures for individual London Boroughs, sex and age groups are, of course, subject to wider variation. All of these projections may be falsified by events.

Populations used in the N.W. Thames plan were therefore 'rounded up to the nearest 10,000 so as to allow a margin to cover any minor fluctuations.'

The S.W. Thames plan uses GLC and County Council forecasts. The S.E. Thames plan uses OPCS estimates of current resident populations; future population estimates are based on OPCS projections using GLC and County Council forecasts of the age/sex structure within the OPCS projected total. The calculations of the London Health Planning Consortium are based on OPCS projections.

A common basis for assessing the requirements for maternity services is the projected number of future births. This is notoriously difficult to predict. The N.E. Thames plan uses GLC forecasts of numbers of births for London and OPCS projections of births elsewhere, the S.E. Thames plan uses OPCS projections of the numbers of females aged 15-44 in 1988 together with 1973 fertility rates; the S.W. Thames plan uses 1977 fertility rates applied to GLC and County Council forecasts of the number of females aged 15-44. The N.W. Thames plan does not consider maternity services.

Population Flows

Decisions on future population flows are crucial in determining the levels and siting of future services, yet each of the Thames Regions treats the question quite differently. In London, with a complex pattern of public transport, administrative boundaries probably have less relevance to patterns of referral and patient demand than anywhere else. It is interesting to recall that the DHSS asked Regions to distinguish between 'natural flows' and those which were undesirable being caused by the historic location of services, though offered no advice on how this exercise might be undertaken.

The N.E. Thames plan seeks to identify population flows in order to 'avoid double counting or underprovision, and to ensure comparability of plans'. To this end, a distinction is drawn between those services which the Region states are provided for a defined geographical area (geriatrics and psychiatry), and those for which no such definition exists (local acute and maternity). The resi-

dent District populations are used for planning geriatrics and psychiatry. Planning populations for local acute services comprise resident populations plus (or minus) an amount based on the current net patient flows (undifferentiated by specialty) between contiguous Districts derived from Hospital Activity Analysis data. For maternity services, planning is based on the projected numbers of births related to the local acute planning population; catchment areas for local acute and maternity specialties are assumed to be identical. (Technically, the net flow approach to estimating catchment populations assumes equal demand (and need) rates in the two adjacent Districts; since the Region uses different 'norms' of provision for some Districts than others, the assumption would seem to be unjustified.) The allowance only for contiguous flows disregards flows from further afield which might seem to be relevant given the Region's observation that 'studies have shown that (patients) tend to go to a particular hospital because it is more convenient to travel to than others'.

Not surprisingly, the two teaching Areas which attract large numbers of patients from outside their boundaries (and outside the Region) complained:

> The two Teaching Areas objected in principle to the use of the proposed planning populations since many of their hospital cases come from well outside the Region and are thus not included.

But the Region argues:

> the method being employed is to allocate the Region's population in planning terms. The issue of how many patients from outside the Region the Regional Health Authority should plan to take as specialist referrals to teaching hospitals is a very important - but separate - one.

The question of extra-Regional flows is one issue which the Region does not explicitly resolve in its plan.

The N.W. Thames plan acknowledges that administrative boundaries may have little significance in determining where patients seek, or are referred for, treatment and care. For acute services, District populations for planning purposes reflect current patterns of flow, as well as those which it is felt should continue. Using Hospital Activity Analysis data, the current catchment populations for each District were calculated by crediting each health District with the proportion of the population resident in each Local Authority area corresponding to the proportion of patients resident in that area treated in that District. (Technically this allows for different rates of demand in different areas - c.f. the N.E. Thames method of calculation). Patients from outside the Region were converted to population equivalents assuming the demand rate pertaining within the District of treatment. The matrix of place of treatment versus place of residence revealed that most health Districts treated some patients from all Local Authority areas in the Region. These population flows were then modified in the light of known changes in hospital provision, though the method of modification is not stated. To calculate future planning

populations for acute services the proportions were then applied to future population sizes and structures using the GLC and County Council projections. For geriatric services, resident populations within health Districts were used. Plans for other services had not been produced when our survey was carried out in 1979.

The S.W. Thames plan uses GLC and Local Authority population forecasts of the numbers resident in each District as a basis for calculating future needs. This assessment appears, however, to be unrelated to what the Region intends to achieve in the strategic planning period. For example, the Region proposes a substantial programme of capital redevelopment for acute services, but it is not clear that this will alter the current patterns of patient flow to match the over or under-provision which the Region calculates for each District. The plan, however, states:

> The over/under provision ... should, however, be considered in the light of cross boundary flows which may cancel out an apparent over- or under-provision.

Though the Region offers no evidence to justify the assumption.

With regards the capital development programme, the plan states:

> Hospital development prior to reorganisation of the NHS had been spread fairly evenly across the Region and development now under construction or in hand will establish the pattern of District General Hospital Development. It will, however, be many years before these hospitals are completed and only modest progress towards achieving the eventual concept of hospital services can be made during the ten year strategic review period.

For acute hospital services, the evidence of the plan reveals an emphasis on capital programming. Concepts such as populations served are secondary considerations.

The S.E. Thames plan uses Hospital Activity Analysis and SH3 data to estimate current catchment populations for acute services in each District. Allowance is made for flows outside the Region. The comparison of catchment with resident populations reveals a number of significant differences, which the Region attributes to 'accessibility' and 'availability'. Predictions of future flows are based on judgements as to which of these two factors were relevant - if the former, the flows would continue; if the latter, and steps were planned to rectify the apparent over- or under-provision, then the flows would cease. In the event, the most significant future flows allowed for were those into the teaching Districts. For geriatric services District resident populations aged over 65 are used with few exceptions. For maternity services, predictions of future numbers of births are adjusted to take account of current catchment flows between Districts.

Identification of 'Needs' and Determination of Levels of Services

All the Thames Regions order their plans on the basis of care groups as requested in the DHSS guidance. These headings provide a

convenient, but not necessarily theoretically sound, framework. For example, certain groupings are not mutually exclusive. False distinctions could produce inappropriate results (the consideration of the elderly separate from acute hospital services may be one such case).

Acute Hospital Services

Acute hospital services are the largest in terms of resources consumed. The Regions distinguish between basic acute service (i.e. those specialties provided in all Districts), sub-Regional specialties (i.e. provided on an Area basis for two or more Districts), and Regional specialties (i.e. those specialties provided in only a very few centres in the Region). Such categorisation does, however, have its problems. There is no absolute definition as to what service constitutes a specialty or into which category it should fall, though the recognition of a service as a specialty and its inclusion in one or other of the three categories could have significant implications on the budgets set for the Area or District in which the service is located. The increasing trend towards specialisation allied to technological advance is particularly relevant in the inner-London teaching Districts, and not surprisingly there has been some debate about the status of such services and whether they should be 'recognised' as 'specialties' for planning and resource allocation purposes. The fact remains, however, that distinctions lack clear definition, and the basis for decisions seems subjective rather than scientific.

Basic Acute Services

The N.E. Thames plan points to the variations in the general levels and quality of primary care throughout the Region which, it is stated, will affect the needs which hospitals will have to meet. Bed provision for local acute services is determined by norms of 2-2.5 beds/1000 total population in most Areas, with 3 beds/1000 total population in the teaching Areas and one other non-teaching District - 'to compensate for poor primary care services in those Areas and for poor socio-economic and environmental conditions', though the effects of these factors on health care needs are not demonstrated. The norms are not differentiated by specialty. The extra bed allowance in the two teaching Areas in inner-London is also 'in recognition of the services they provide for commuters and of the undoubted second referral function of their four teaching hospitals'; the teaching Districts in one Area have been allowed an additional 325 beds for 'unrecognised specialist services' in the teaching hospitals. These norms of provision imply a substantial reduction in the number of beds, (see table 1) particularly in the inner-city Teaching Areas. It is anticipated that those beds remaining will function at higher levels of throughput and to this end attention is drawn to the general need for complementary supporting diagnostic and treatment facilities. The Region proposes to develop day surgery and programmed investigation units 'to the maximum extent possible', though the envisag-

Table 1
Planned Acute Bed Changes in the N.E. Thames RHA

Area	Numbers of Available Beds 1976	1988	% change
Essex	3571	3891	+9
Barking and Havering	1629	1199	-26
Camden and Islington (T)	2757	2200	-20
City and East London (T)	3752	2665	-29
Enfield and Haringey	1707	1414	-17
Redbridge and Waltham Forest	1588	1315	-17

Local Acute, Regional and sub-Regional specialties.
Source: SASP3 tables for Areas.

ed level is not stated in quantitative terms. The highly variable pattern (up to a tenfold variation) of out-patient referrals from District to District and from general practitioner to general practitioner is mentioned, but no specific plans for out-patient services are put forward. (The corresponding SASP table quantifies the Regional position for out-patient services in 1988 showing that total attendance will decrease, though this is a simple statistical projection rather than a reflection of actual plans for out-patient facilities).

The N.W. Thames Region acknowledges that: 'there is no way in which the current needs for hospital beds can be measured'. The target figures which the Region calculate represent 'the best attempt that can be made to share equitably between Areas'. Based on current experience in one outer-London District, self-sufficient with acute provision concentrated in the DGH, the Region calculates that the numbers of beds required is equivalent to a norm of 2.18 beds/1000 population. This basic norm is then adjusted to take account of 'special local factors' which are thought to be relevant to needs, in particular the age distribution of populations and the effects of social deprivation. An analysis of Hospital Inpatient Enquiry (HIPE) data revealed the usage of beds to be highly age specific; thus, the Region calculates that the basic norm of 2.18 should be increased or decreased by 0.05 for every 1 percent variation from the proportion of the population aged over 65 existing in the sample District on which the basic norm was calculated. With regards social deprivation, the Region indicates that it has examined a range of alternative weighting factors which were rejected as inadequate, but which suggested that social deprivation was most marked in central London (principally its two Teaching Areas). Faced with this difficulty, the Region opts for a simple solution. The total number of beds will be determined by financial considerations and the pace of change which is practically possible. The Region proposes only a 15 percent reduction over the decade 'in order to free funds for the development of priority services' (which are not considered in the plan). This will allow teaching Districts to have as much as 48 percent over the basic normative bed require-

ments in recognition of their special needs. The application of these principles in one Area is indicative of the approach:

> For the Brent and Harrow Area, the position is complicated by the fact that weighting for social deprivation applies only to the Brent District and weighting for research to the Harrow District ... since both elements which justify the weighting apply to only half the Area, the weighting for the Area as a whole amount to 24 percent....

The Region leaves it to the Area to decide how in fact the 24 percent supplement should be distributed.

The S.W. Thames Region states that its broad objective is 'to maintain acute services without deterioration as financial limits on growth will generally result in a standstill of services.' Reference is made to a hospital development programme which was initiated prior to reorganisation and which is still in progress. This will establish a pattern of DGHs throughout the Region, though only modest progress is envisaged over the strategic planning period. Included in the plan is an inventory of all District General and support hospitals which seems indicative of an institutional and capital-led approach towards planning.

To calculate levels of provision in each District, norms are applied to 'managed' (essentially resident) populations. For adult acute beds (excluding ENT, ophthalmology and Regional specialties) a norm of 2.16 beds/1000 population is used. It is not clear on what basis this norm has been derived. The use of such an approach seems, however, to be notional; the resultant pattern of services will be determined by the achievements of the pre-determined capital programme rather than the application of any norm. For example, based on the figures quoted in the plan, table 2 shows the programmed changes envisaged for the next decade, which do little to redress the calculated imbalances. Of particular importance is the bed provision in the teaching District. This involves the major development of a teaching hospital. The size of the student intake is the primary factor influencing the level of provision for that District. (The intake size is 160 and the Region assesses that 1600 beds are required - using the Todd formula of 1000 beds for an intake of 100 students; in the event, a teaching hospital of 1200 beds is planned for practical reasons with the need to use 400 beds at alternative hospitals. This provision of 1200 beds in one hospital compares with the Region's calculated need of 812 beds for the whole District). References are made to the increased demand on acute medicine caused by increasing numbers of elderly and inadequate primary care, though no attempts are made to quantify these factors. No plans for out-patient and day-patient facilities are discussed.

The S.E. Thames plan points to the fact that the Region as a whole has higher bed provision than the national average and that this leads to higher demands and usage. Within the Region the provision is unevenly distributed, with over a twofold difference evident among Districts, even when current population flows are taken into account. Over the last decade, there has been an increasing trend of activity in the acute sector. If this trend were to continue it would imply an increase in expenditure of 27.5 per-

Table 2
Adult Acute Beds* — Proposed Changes Over The Next Ten Years in S.W. Thames RHA

District	Current bed Provision *	1988 Calculated Need *	Proposed Changes (Nett)	Shortfall/ Overprovision (-/+)
Surrey North	330	303	0	+ 27
Surrey North West	499	493	0	+ 6
Surrey West/NE Hants	395	562	0	-167
Surrey South West	551	578	-56	- 83
Surrey - Mid	457	400	0	+ 57
Surrey - East	548	436	-68	+ 44
Chichester	378	420	0	- 42
Cuckfield & Crawley	491	754	+25	-238
Worthing	513	583	0	- 70
Croydon	634	747	0	-113
Kingston & Richmond	553	547	- 8	+ 2
Roehampton	390	316	0	+ 74
Wandsworth & E Merton	1315	812	yet to be agreed+	
Sutton & W Merton	761	675	+95	+201

* including regional specialties
\+ the Plan indicates the development of a 1200 bedded teaching hospital

cent which the Region concludes is clearly not possible. The Region has proposed the use of acute bed norms based on national age and specialty specific bed usage rates derived from 1973 HIPE data, and weighted by overall Standard Mortality Ratios (SMRs) for Areas. These norms are equivalent to a Regional norm of 2.4 beds per 1000 population. Three Areas have used the norms proposed by the Region, though with a number of modifications which attenuate the scale of change proposed; from the discussion in the plan it is evident that those three Areas will have a number of significant practical problems to resolve before the theoretically calculated levels can be achieved. But the major problems exist within the Teaching Area (Lambeth, Southwark and Lewisham AHA(T)) which has not used the Regional norm. The Region states its problems thus:

> The Area has relatively higher levels of social deprivation, a falling population, high proportion of older general practitioners and an alleged excess of 'lock-up' surgeries. In addition the Area has insufficient Mental Illness facilities and almost no Mental Handicap facilities and ... is one third above its RAWP target and is moving away from that target at a pace of about £0.9m per annum. Thus, the Area is required in the next decade to contribute to the redistribution of resources between areas and also to fund revenue to support the development of its deprived long-stay services. The only major sources of redistribution lie in its acute beds and reduction of these, so far as the teaching specialties are concerned, will interfere with the Area's ability to provide sufficient teaching material to meet its undergraduate commitments.

The Area currently has 2557 acute beds; according to Regional norms 1910 beds are needed; for teaching purposes the requirment (according to UGC norms) is 2020. The Region calculates the Area to be £35m above its RAWP target, but has asked for a financial saving of between £6.5m and £12.5m over the decade. The Area plan was based on the assumption that revenue expenditure would remain constant. The resolution of this problem is the crucial feature upon which the Region's plan depends.

Against this problematical background, it seems somewhat frivolous to note that the Region does not describe plans for out-patient or day-patient services.

The London Health Planning Consortium used national age, sex and specialty specific in-patient demand rates applied to the future resident populations of Local Authority areas. Allowance was made for trends in those rates based on 14 years retrospective national data, and for local variations in demand by assuming a direct relationship between demand rates and Standardised Mortality Ratios. Where the projected demand rate was lower than currently experienced, it was adjusted to a position mid-way between current and projected rates. This adjustment is essentially arbitrary. The beds required were estimated assuming projected lengths of stay and bed turnover intervals. These were based on what was felt to be achievable given current practices; in some specialties, in teaching Districts, longer lengths of stay were assumed. Having calculated the beds required the significant assumption was made that the pattern of patient flows would remain unchanged. This approach was applied to all acute specialties including Regional specialties. Overall, an 11 percent reduction in acute beds was calculated, though the resultant position is still considerably in excess of the rate of acute provision planned for the rest of the NHS.

Sub-Regional Specialties

The N.E. Thames plan notes that ENT, ophthalmology and orthodontics have a high out-patient workload and the Region proposes to provide out-patient services in each District, though specific levels are not stated. The siting of in-patient services is determined by geographical considerations in outer-London and by existing facilities and the needs of under-graduate teaching in the inner-London Areas. The plan does not include quantitative statements of levels of provision. The N.W. Thames Region does not consider these specialties in its plan. The S.W. Thames Region uses a norm of 0.075 beds/1000 population for ENT in-patient services with a norm of 0.075 places/1000 population for day care services, though again these levels seem to be somewhat nominal since the effects of the capital programme will determine the scale and siting of services rather than any normative calculations. The S.E. Thames Plan includes dermatology, ENT, ophthalmology and dentistry in its list of sub-Regional specialties. Reference is made to working groups established to consider these specialties, and until these exercises are completed no firm plans are produced. The Region states that: 'in these circumstances, the current Area plans understandably make little difference to these non-District specialties'.

Regional Specialties

The N.E. Thames Region has designated as Regional specialties: cardiothoracic surgery and cardiology; neurosurgery and neurolgy; radiotherapy; haemodialysis and renal transplant; plastic surgery (including burns); neonatal intensive care; communicable diseases; psychiatric medium secure; child and adolescent psychiatry. The Region acknowledges that planning can only be done 'rationally in relation to the needs of the whole of London and South-East England'. Proposals for siting particular services are based on current locations, though it is not clear on what basis the levels of these services have been determined. The Region designates high security communicable diseases, medical oncology, tropical diseases and haemophilia as supra-Regional specialties and provision is based on existing facilities.

The N.W. Thames Region does not consider Regional specialties in its plan. Though the S.W. Thames plan mentions Regional specialties, the constituent specialties are not listed, let alone any attempt to explain on what basis levels of services have been calculated. The S.E. Thames plan states that the position with regard Regional specialties is somewhat 'complicated'. The plan states that: 'whilst some examination has been initiated in respect of a few designated specialties, the Authority recognises that the main issues still remain unresolved, and will need to be tackled in the near future'. Thus, no plans are described for Regional specialties.

Primary Health Care Services

The three Regions which considered primary care services all point to the problems of the General Practitioner services particularly in the inner-London, 'socially deprived' areas where there are higher than average proportions of older GPs practising single-handed from lock-up surgeries with small list sizes. The quality of the service together with the absence of an 'out-of-hours' service is thought to place increased burdens on acute hospital facilities. The Regions acknowledge that they cannot influence matters directly; as the N.E. Thames plan states:

> Though the Region has a major stake in the provision of some of the elements of primary care and has a major interest in the improvement in the quality of primary care, it has only very limited and indirect control of and influence over the single most important element, namely the pattern of general practice.

Within their spheres of influence the Regions hope to improve matters by providing improved facilities (health centres), better levels of community nursing and the promotion of the primary care team concept, and by influence at the teaching and training levels.

All three Regions mention preventive services as being a priority, though the problem is acknowledged as being one of attitudes rather than resources. The general tone is one of exhortation and

education rather than specific programmes of action. One Region points to the fact that prevention 'is not the sole responsibility or prerogative of the health services', rather other agencies particularly Local Authority departments have important roles to play.

Services for the Elderly

All four Regions point to the increasing numbers of very elderly (over 75). The needs of this care group exemplify the necessity for a joint approach involving health, personal social services, housing, and the private and voluntary sectors (4). Yet planning tends to be fragmented. Within the NHS, consideration tends to focus on the provision of geriatric beds, though on average about 50 percent of so-called acute beds are occupied by patients aged over 65 (and not all Regions use age specific norms for calculating acute requirements). The linkage between acute and geriatric services is crucial. Though the strategic plans do make general references to complementary community and Local Authority services, on no occasion are planned levels of provision varied so as to provide a balance with the levels of service provided by other agencies. Little mention is made of the voluntary or private sectors.

The N.E. Thames plan points to the arbitrary distinction of 'acute' and 'geriatric' hospital provision:

> There is in fact a complementary relationship between acute and geriatric services which tends to be concealed by the use of separate planning norms.
>
> The extent to which there has to be separately identified designated geriatric provision ... will vary according to overall levels of provision and local practices. It has however been necessary for the establishment and early development of hospital services geared to the needs of the elderly to treat geriatrics as a separate specialty with its own separate services.

But the Region is committed to reducing acute services, and its strategy concentrates on geriatric services. The Region endorses the view that community care is preferable to institutional care and to this end hopes to develop community services. The Region points to the interdependence of health and social services and housing services, and indicates that all Local Authorities fall short of target norms (some falling 'very short').

The N.W. Thames plan makes no mention of out-patient, day-patient or complementary Local Authority provision. The S.W. Thames plan concentrates essentially on geriatric services and with the exception of seeking 'to encourage better communication between primary care teams, hospitals, social services and other relevant departments', little mention is made of Local Authority social service or housing provision. Only the S.E. Thames Region has undertaken a comprehensive examination of the problems. The report of this exercise (5) embraced the whole spectrum of ser-

vices for the elderly and was issued as a basis for Areas to establish their plans, and the Regional plan summarises what has been proposed. The Region points to the need for collaboration with Local Authorities to provide a comprehensive service for the elderly, and envisages that the joint financing monies will be used to develop complementary social services for the elderly.

Though all Regions draw attention to the significance of the large projected increase in the size of the population aged over 75, within a generally stable population aged over 65, only two Regions take account of this feature in their choice of norms.

The N.E. Thames plan used norms of 10 beds and 3 day places per 1000 population aged over 65. The S.W. Thames plan used similar norms but indicated that by the end of the decade services would fall considerably short of the theoretical norms. The N.W. Thames plan transformed the norm of 10 beds/1000 aged over 65 into a norm of 28.5 beds/1000 aged over 75 to reflect the changing age structure; but when this norm was applied it resulted in a requirement almost twice the existing provision, and the Region therefore chose a lower norm of 24 beds/1000 aged over 75 except in six 'socially deprived' Districts where the higher figure was used. The net effect was a projected 55 per cent increase in bed provision. The S.E. Thames plan used age specific norms of 2.612 beds/1000 aged 65-74 and 16.356 beds/1000 aged over 75. These norms produced a projected increase of 18 percent in the number of beds required, though Area plans fall 10 percent below the calculated target. For day care services, the S.E. Thames plans used a norm of 2 places/1000 over 65.

The four alternative sets of norms if applied to the same population would produce significantly different levels of service. The decision to choose a particular approach is essentially arbitrary.

Services for the Younger Physically Disabled

The younger physically disabled group includes those under the age of 65 with physical disabilities, the deaf and hard of hearing, and the blind and visually handicapped. Such simple definitions cover a heterogeneous group in terms of degree and type of disability. Local Authorities have a duty to maintain registers as a result of the National Assistance Act of 1948 and the Chronically Sick and Disabled Persons Act of 1970, but many who might qualify as disabled fail to register. It is, therefore, difficult to establish the real needs for planning such services. Both the Local Authorities and voluntary organisations make important contributions to the care of the disabled, and again a joint approach is essential.

The N.E. Thames plan states that the special problems of the younger disabled is a recently recognised need affecting both health and personal social services. The Region proposes that 0.06 hospital places/1000 population aged 15-64 be used flexibly for day patients, short stay assessments, holiday relief and for long term care including terminal care. The Region notes that Area plans make no reference, and presumably no allowance, for this care group. The S.W. Thames plan states that in recent years there

have been varying opinions on the level of provision required, but the initial aim is to provide accommodation on the basis of 0.06 beds/1000 population aged 15-64 years. When this has been achieved, which is likely to be in the 'fairly long term rather than the short term future', the need will be further reviewed. Taking account of proposed changes in the ten year period the shortfall is of the order of 60 percent of the calculated need. The S.E. Thames plan also uses the norm of 0.06 beds/1000 population aged 15-64, though emphasises the importance of community and social services as well as the contribution from the voluntary sector. The plan notes that only two Areas have made specific proposals for this care group in their plans.

Services for the Mentally Ill

In 1975 a White Paper Better Services for the Mentally Ill (6) established national policy. In essence, a move away from institutionalised services was proposed.

The current pattern of services for the mentally ill in the Thames Regions is based on a few large institutions. The three Regions which included proposals for this group indicate factors which inhibit progress towards the national policy. The N.E. Thames plan acknowledges that: 'the level of community services provided by the Local Authority social service departments will have a major effect on the type and quality of service provided by the health service. Most Local Authority provision falls short of the target levels ...'. The Region hopes for improvements through joint financing. The S.W. Thames plan points to problems to be resolved if the size of the in-patient population is to be reduced: 'The present in-patient population contains many Stateless residents, that is, those residents for whom no local authority will accept responsibility for housing and for whom the hospital is home. Many are frail elderly people. In addition, other patients have grown old in hospital - at present no alternative accommodation is available'. If patterns of service are to change then 'an active policy of cooperation between authorities and positive discrimination in the allocation of resources' are needed - presumably the Region will contribute to this process. The S.E. Thames plan points to the inherited institutional pattern of care centred on a few very large hospitals. There has been a trend steadily to reduce the total bed numbers and some progress in providing beds in smaller District based units. The Region points to complications, however, in the fact that five of the seven large institutions serve Districts outside the Areas in which they are situated; some Districts have little by way of local facilities.

Proposals for the future indicate differences in the approach and urgency with which problems will be tackled in the three Regions. The N.E. Thames plan projects substantial change in the pattern of services, with a 20 percent reduction in in-patient care, a 25 percent increase in out-patient attendances, and a 155 percent increase in day hospital attendances. The norms for adult mental illness are 0.8 hospital beds/1000 population (including 0.3 beds for the new long stay element), and 0.3 day hospital

places/1000 total populations. Out-patient, day-patient and in-patient facilities will be provided in each District, though the former levels are not quantified. The development of community psychiatric nursing is also proposed, though again no quantitative levels are specified. The norms of provision used to determine services for the elderly severe mentally infirm (ESMI) are 3 beds and 2 day places per 1000 population aged over 65. In addition, 10 to 20 beds should be provided in each District, ideally at the DGH, comprising a 'psychogeriatric assessment unit'.

The S.W. Thames plan indicates that no detailed strategy will be proposed until a multi-professional working group has been established and made recommendations. The DHSS priorities for this group are endorsed, but the Region estimates that only a gradual rate of change is expected based on present resource assumptions. The plan states:

> The main psychiatric service should be provided by the primary health care team and secondary provision should in the long term (10 - 25 years) be provided in each Health District by hospital psychiatric units of 90 - 120 beds (or smaller following reappraisal) and the appropriate number of day places, but the ideal of a District based service cannot be achieved in the next ten year planning period.

The Region points to the need to rationalise catchment areas for the mentally ill. The services required are calculated on a District population basis using norms of 0.5 beds and 0.65 day places/1000 population for adult mental illness, and 2.5 to 3 beds and 2 to 3 day places/1000 population aged 65 for the elderly severe mentally infirm. These calculations point to the need for substantial change from an institutional pattern of service currently based on a number of very large (1000 bedded plus) hospitals.

The S.E. Thames plan indicates that an examination of Regional policies has been undertaken and the report of this exercise (7) has been issued for consultation. The use of a range of norms is proposed: for adult mental illness - 0.91 beds and 0.65 day places/1000 population; for the elderly severe mentally infirm - 2.5 beds and 2 day places/1000 aged over 65, and 1.15 assessment beds/1000 population aged over 75. Regional requirements are assessed by applying norms to the Regional population. The allocation of these beds to Districts is effected 'by means of a demand measure based on age, sex and marital status characteristics of each Health Districts resident population'. The Region discusses the various proposals from the Areas in its plan; in general they conform with the trend of decreasing institutionalisation. By the end of the decade an excess of beds and a deficit of day places is apparent, and the proposals of different Areas need to be harmonised by redefining catchment populations.

Services for the Mentally Handicapped

National policy for the mentally handicapped was embodied in the White Paper titled Better Services for the Mental Handicapped (8)

published in 1971, and extended by the National Development Group (abolished as a 'quango' in 1979). Emphasis was placed on locally based services caring for patients in the community as opposed to the historical institutional pattern. As with their plans for the mentally ill, the three Regions which considered this group indicate differences in approach and apparent urgency towards tackling the problems, if anything they indicate a more restrained attitude towards changing the pattern of care.

The N.E. Thames plan uses the established norm of 0.68 beds/1000 population (0.55 adults, and 0.13 children) to assess future requirements, though the Region believes that if community services are developed, lower (unspecified) norms might be adequate. At present the majority of in-patient provision is in one outer-London Area. The Regional policy is to run down large institutions and to spread provision throughout the Region in smaller units, a policy which will, however, depend on the Local Authorities giving increased priority to community services. Emphasis on short-term care and community services will increase the requirement for appropriately trained staff. A 'very substantial increase' is envisaged in the amount of day care required. Having identified the optimum pattern of services, the Region states: 'there will be no possibility of achieving this pattern of provision throughout the Region ... within the strategic decade on present resource assumptions'. Indeed, it is not clear precisely what the Region has planned to achieve.

As with mental illness services, the S.W. Thames Plan propounds a number of worthy principles then states that: 'it is unrealistic to assume that major advances towards the implementation of these propositions during the period of the current Regional Strategic Plan'. The general drift of Regional policy is to shift the emphasis from hospital to community care, depending for the latter on the general practitioner and the Local Authority services. Though no hospitals are earmarked for closure during the strategic period, it is proposed that the occupancy of the large hospitals will be reduced. A number of capital developments are listed in the plan to improve the atmosphere and general environment of those institutions. The calculation of the needs for mental handicap beds and day places are based on the established norms of 0.68 beds and 0.16 day places/1000 population applied to District resident populations. In comparison with the changes actually planned during the decade these calculations show that the position in 1988 will be one of a large excess of beds and a large deficit of day places.

The S.E. Thames plan indicates that its policies for mental handicap have been issued separately for consultation (9). Again the nationally established norm of 0.68 beds/1000 population is recommended. The Region indicates that the current pattern of services is based on a few very large hospitals, with only a small provision (43 places) of day places in four Districts. For the future, the closure of one large hospital is under consideration which creates uncertainty about future requirements and financing in those Areas affected. The Region indicates differences of approach in the Area plans including emphasis on prevention and the need to create Community Mental Handicap Teams to provide support in the community. With regards hospital services, future

planned bed provision across the Region will broadly equate with normative requirements, though imbalances between Districts are evident.

Services for Children

Since the inception of the NHS, health care for children has come from three independent sources - the Community Child Health Service (formerly the Maternity and Child Welfare and School Health Service), General Practice, and the hospital and specialist Service. The challenge is to integrate services into an effective whole. The report of the Court Committee (10) published in 1976 emphasised the need for an integrated service, as well as stimulating some debate on factors affecting perinatal and infant mortality, on the preventive aspects of children's services, and on the changing patterns of need with chronic illness, handicap and psychiatric disorders assuming increased significance.

But policies 'to integrate', or 'to reduce infant mortality', are not readily translated into specific programmes for action. The N.E. Thames Region proposes a strengthening of primary care teams by increased provision of health visitors, and maintenance (or possibly improvement) of staffing levels generally, particularly in Districts with high infant mortality rates. The Region indicates that the school health service should concentrate on surveillance and education, and that developments are required in services for children with specific handicaps (e.g. speech, hearing or sight). The S.W. Thames plan states that 'by the end of the decade limited progress will have been made in improving children's facilities', though the Region feels that hospital services are 'reasonably adequate'. A number of 'significant developments' in child health care services are listed in the plan which require 'additional funding' which the Region hopes Area Health Authorities will take account of (though where Areas might conjure the money from is not ellucidated). The S.E. Thames plan lists a range of proposals which have been produced by Areas and indicates that an examination of the 'whole spectrum of health service for children' will be undertaken.

More specific proposals are evident for hospital services. In N.E. Thames, a norm of 0.3 beds/1000 total population is proposed, with a nominal 10 beds in each District as an addition for assessment and the intermittent and long-stay care of handicapped children. The presence of the hospitals of the Institute of Child Health within the Region is welcomed, but this has caused problems in agreeing appropriate levels of service in one Area where one of the hospitals (148 beds) is sited. The S.E. Thames plan includes a range of norms applied to District resident populations: acute - 0.19 beds/1000 total population; mental handicap - 0.13 beds/1000 total population; mental illness - 0.02 to 0.025 beds/1000 total population; adolescent psychiatry - 0.02 to 0.025 beds/1000 total population. When these calculations are compared with planned changes over the decade, they reveal an apparent overprovision (in excess of 25 percent of the calculated need) of children's beds. The Region cautions that the apparent under-utilisation of beds currently in many Districts may be misleading since lengths of

stay are often short which results in low occupancy rates; if this factor is as significant as the Region implies it would have been better to attempt to quantify it and include it explicitly in the calculations.

Maternity Services

National policy is that resources devoted to the maternity sector should decline in line with the falling numbers of births. During recent years, however, the OPCS has continued to predict an up-surge in the numbers of births - a prediction which has been repeatedly postponed in successive years as the numbers of births continued to fall. At last there is evidence that the annual number of births has 'bottomed-out' and Regions generally take this to signify the long awaited bulge. Planning is being based on projected increases in births (up to 50 percent in some Provincial Regions). Over the last decade, there has been a failure to respond to the falling demand for maternity services which unlike many aspects of health care has a clearly defined need (11). The maternity sector also has a clearly defined outcome - perinatal and maternal death. High death rates still exist, with wide variations between different geographic areas, which are not correlated with the level of maternity services (12).

In acknowledging the uncertainty of future birth rates, the N.E. Thames plan emphasises the need to be flexible, and possibly to adapt quickly. To provide for 100 percent hospital confinement, the proposed norms of provision are 27.5 beds and 5.5 special care baby cots per 1000 total births. These will be provided in the main in consultant units with provision for general practitioner facilities, should there be the demand. In rural parts, however, concentration of GP facilities may not be appropriate; in these cases, the Region expresses 'hope' that GPs will consult obstetricians over the selection of patients. With regards ante-natal care, it is stated that an unsatisfactory proportion of 'late bookings' is evident and further that the care received after booking is inadequate. Whilst the expenditure on maternity services is projected to remain constant, rationalisation of hospital provision should produce savings to enable the improvement of antenatal care through the development of pre-natal screening programmes and increased staffing levels. The high illegitimacy rates in inner-London and the high proportion of private abortions are quoted as evidence for the need for urgent action to provide NHS serices. The need for abortion services is estimated at 50 abortions per year/1000 women of child bearing age. The Region states, however, that Area plans give little attention to these services 'presumably because the capital implications are minimal'.

The S.W. Thames plan acknowledges the uncertainty surrounding predictions of numbers of births. The Region estimates that bed provision will probably be adequate to accommodate the demands. Bed needs are calculated on the basis of 27.8 beds per 1000 total births and, taking account of planned changes, the provision in 1988 will broadly equate to the calculated bed need. The Region places emphasis on improving the take-up of antenatal care, education programmes and the need to encourage 'at-risk' women to use

modern maternity facilities, particularly in socially deprived areas.

The S.E. Thames plan indicates that the RHA has adopted a report which promulgated the objective of reducing perinatal mortality rates and the incidence of handicapped babies. To this end improved antenatal care and the rationalisation of obstetric provision in properly equipped consultant units was envisaged. The evidence of the Areas plans indicates a general acceptance of these unexceptionable objectives, but an absence of detailed plans for action. Levels of in-patient services are based on norms of 28.2 beds and 6 special care baby cots per 1000 total births. Planned provision by 1988 broadly equates with these levels except in the Teaching Area which proposes to maintain current levels. These exceed the Region's assessments of need by almost 50 percent for both obstetric beds and special care baby cots.

Associated Levels of Provision in Complementary Services

There are a range of supporting services. Under this heading, the N.E. Thames Region discusses ambulance services; supply services; estate management; scientific services; pharmaceutical services; computing services; education and training. These services are considered only in general terms unrelated to the plans for different care groups or particular Areas. Similarly, in the S.W. Thames and S.E. Thames Plans, a range of supporting services are considered, though the implications for such services of changes in basic services are not quantified. No mention of such facilities is made in the N.W. Thames plan.

Assessing Feasibility

A primary criterion adopted to test the feasibility of the N.E. Thames plan is revenue money. The application of RAWP-type principles and the use of the Region's planning populations led to the conclusion that there was a substantial imbalance in geographical distribution between inner-London Teaching Districts and outer-London Areas. The application of national policies and standards of provision also indicates an imbalance between care groups throughout the Region. The need to rationalise and redevelop services in inner-London led to decisions on a programme of major hospital building and a consequent extensive programme of hospital closures and changes of use. This programme of redevelopments is the cornerstone of the plan. The Region indicates that this programme has been costed (but not how), and the corresponding SASP table shows a broad balance at the end of the strategic decade between savings and additional expenditure associated with large capital schemes (£0.5m and above). A profile of revenue and capital expenditure year by year is not shown. In view of the scale of change proposed, the synchronisation of capital and service development and resource redistribution appears to be crucial.

In evaluating revenue consequences, the Region acknowledges the poor state of costing information for planning, and indicates the

range of assumptions made in patient activity statistics and unit costs. The net result of these broad assumptions and the unpredictable 'slippage' in the planned timescale associated with major building projects, must be to create some uncertainty about a plan which is heavily committed and tightly constrained. The overall financial position implies a growth rate in revenue terms of 1 percent per annum over the decade. From the scale of change proposed, the plan will have very significant manpower implications. The Region acknowledges this to be complex:

> while it has been possible to prepare a reasonably detailed strategy for senior medical staff requirements in the decade to come, the strategy for nursing, junior medical and other grades of staff has had to rely upon extrapolation derived from anticipated patient loads...

Given the absence of any real manpower planning, there must be further uncertainty about the feasibility of the plan, whatever the calculated financial position at the end of the decade.

The N.W. Thames plan for acute and geriatric services was designed to achieve revenue savings for developing other priority services. The Region states, however, that it was not possible to calculate savings since the involvement of Areas would be necessary to determine how proposed changes could be translated into practice. A further consideration, the availability of capital monies and the phasing of capital schemes, would be an important limiting factor. Thus, only tentative estimates have been made of the financial implications. The Region considers what options exist should savings not reach the levels desired and concludes that little room for manouevre seems possible. With regards financial allocation with the Region, it is proposed to move from a theoretical RAWP-type formula to a financial plan 'to mirror the planned provision of beds and services'. Such a plan has yet to be formulated. Broad attempts are made at assessing the medical and nursing manpower implications of the plan. For medical staff, consideration is limited to consultants. Whilst overall no significant increase is envisaged, no analysis has yet been undertaken by specialty, nor has account been taken of changes in the distribution of caseload between acute specialties which might occur. The Region proposes to produce a more detailed medical manpower plan. More detailed attempts are made to estimate nurse staffing changes implicit in the plan. Attention is drawn to the fact that information on trained and untrained nurses is not collected on a suitable basis for planning purposes; data are available by hospital, but not by specialty or specialty groups. Using a model which assumes current staffing ratios, and modifications for increased throughputs and variations in numbers of teaching beds, future nurse staffing levels are calculated. The results presented indicate the need for substantial changes, particularly as a result of changing patterns of work resulting from GNC regulations, EEC directives, and the reduction in hours worked per week.

The S.W. Thames Region has a pragmatic approach towards what is possible and what is not. The national priorities are endorsed in principle, though the Region calculates that to meet the needs of the priority services when their revenue money remains constant

would require the reduction of 3000 acute beds which the Region concludes is 'clearly unacceptable'. Indeed, the Region emphasises that: 'the provisional allocations are such that it is doubtful whether the Region will be able to maintain its present position with regard to levels of service'. Despite this position the Region urges Areas:

> to direct any surplus moneys or savings from rationalisation into the priority health care groups. Without a financial reserve to back up changes in direction it would be impractical to make definitive statements for implementing such changes. Therefore, it should be left to Area Health authorities to determine how and when the criteria can best be met.

This seems a forelorn hope, if not an abrogation of the Regional role. In a final section of the plan the national priorities are listed as unobtainable objectives. The Region indicates that attempts have been made by three of the five Areas to cost their respective proposals. Those Areas 'balanced the anticipated expenditure against the likely resource assumptions' though no indication is given of the basis upon which Area financial targets were set in the first place. The costing procedure is restricted to marginal changes, a major consideration being the revenue consequences of capital schemes. Where capital schemes 'have not been programmed by Region' this has left Areas with 'unallocated revenue balances' - statements which seem indicative of the lack of integration between capital, revenue, or even service planning intentions. The Region has also attempted a broad brush costing of the plan by care group 'to show whether the plans are within the realms of possibility.' No attempt has been made to evaluate the revenue consequences of intervening years. For each of the basic groups of services the Region indicates the proposed capital changes. It is not clear, however, to what extent these proposed capital schemes have been evaluated technically, or even costed; nor is any indication given of the timing of the projects. The plans for each care group include a discussion of the manpower implications; these are not always presented in quantitive terms, though the Region acknowledges the importance of manpower planning and the need to develop the appropriate skills and the information base.

A major feature in the S.E. Thames plan is the problems of the Teaching Area, and until this can be resolved any strategy for the Region must be couched in uncertainty. Having considered its policies for particular care groups, and the proposals of the Areas, the Region then attempts to reconcile these with the total resource assumptions within which it had been asked to plan. This is complicated by the fact that Areas were given an upper and lower revenue limit within which to plan established according to RAWP-type principles. For each care group the Region puts forward its preferred option for 1988. These differ substantially from the proposals contained in Area plans, particularly in the Teaching Area.

No indication of the pattern of expenditure during the decade is given, nor how the changes proposed would be synchronised. With regard to capital expenditure, the plan states that: 'in broad

terms the shape of the capital programme, as described in Area plans, does not appear to be inconsistent with Regional and National objectives and priorities'. The Region notes, however, that 'the capital programme will need to be revised if the resulting revenue requirements cannot be met'. The Region indicates that only one Area made any attempt even to complete the SASP table relating to the manpower consequences of its proposals, let alone undertake any real manpower planning. The Region attempts a broad assessment of medical and nursing implications, but not for other grades of staff. The Region concludes that the plans to contain the acute sector are uncertain, and that developments in the non-acute sector fall short of what is desirable, given the resource constraints applied on the Region.

Medical Education in London

Sir John Ellis, the Dean of the London Hospital Medical College, has recounted the problems of medical education in London (13):

> London now has 12 university medical schools and 12 university medical centres and numerous university post-graduate institutions. The additional moneys which have brought about the change were recommended for the academic development of six paired schools - but when they came they came to all, in varying quantities, and without reference to any kind of overall plan. The result, it must be faced, is a bigger muddle than Todd set out to try to solve in 1965, compounded by collapse of the national economy and all the other difficulties that has brought in its train.
>
> But the deterioration as brought one great advantage, for whatever is proposed now as the solution to the problem of London will be proposed to people who cannot possibly fail to see that there are problems. Ten years ago that was not so. London's past success had given it a slight touch of the Mohammed Ali syndrome. So London stuffed its unacceptable problems under the carpet, sat a steering committee on the middle of it and joint policy committee round the edge, and went on regardless. Now inevitably a decade later, as the 30 or so university medical institutions collectively face independent bankruptcy, the carpet has been pulled smartly away - revealing the same old problems which have gone a bit mouldy and grown some new ones, as things do after 10 years under a carpet.

He argued that London is particularly well placed to provide all that is appropriate for excellence in medical education, and described what is necessary for a twenty-first century medical school. He did not, however, address the issue of the scale of medical education in London.

In March 1979 a working party was set up by the University of London under the chairmanship of Lord Flowers to enquire into the need to redeploy resources to maintain the present standards of medical and dental education in London. The report from the working party was published in February 1980 (14). Amalgamation of the

34 existing schools and institutes into 6 new schools was proposed. The postgraduate institutes and some undergraduate schools would lose their separate identity; pre-clinical courses at two hospitals would be phased out; and one undergraduate medical school would close. These proposals were greeted with predictable criticism from the medical profession.

The report seemed to discount the effects on local health services of meeting the needs of medical education. The working party's terms of reference included the assumption that student numbers would be maintained, and that total funding would not be reduced. Yet the costs of running teaching hospitals have to be met from District budgets and the costs of teaching have never been satisfactorily identified. The integration of the postgraduate hospitals (which were not included in the 1974 reorganisation) into the District administrative framework, as proposed by Flowers, would inevitably give rise to further complex questions of financial allocation and service provision.

It is not yet clear to what extent the Flowers Report will be implemented. A so-called London Advisory Group (LAG) has been established by the DHSS to promote change. Already there is doubt whether the Flowers recommendations will be acted upon, and it has been claimed that: 'there is a growing belief that none of its major proposals will be implemented' (15).

The London Health Planning Consortium

In May 1978 a letter from J.C.C. Smith, an under-secretary in the Regional Group of the DHSS, to Regional and Area Administrators and Secretaries of Boards of Governors outlined the composition and purpose of the recently formed London Health Planning Consortium (LHPC). The London Co-ordinating Committee established in 1975 had resolved to let London Regions and Areas themselves undertake the introduction of the NHS planning system. The strategic planning activities of the various authorities revealed the need for a plan for London as a whole and thus the LHPC was established. Its terms of reference were:

> To identify planning issues relating to health services and clinical teaching in London as a whole; to decide how, by whom and with what priority they should be studied; to evaluate planning options and make recommendations to other bodies as appropriate; and to recommend means of co-ordination planning by health and academic authorities in London.

The Consortium included representatives of the four Regions, the University Grants Committee, the University of London, and the DHSS; notably no Area or District representatives were included. It was emphasised in the letter that the LHPC was 'neither a decision making nor an executive body'. Decision making would remain in the hands of Ministers and the statutory authorities. Subsequently, with the publication of its two main reports, the LHPC seems to be acquiring a more legitimate status, and its analyses are being represented in the media as 'plans for London'.

In 1979, 'Acute Services in London - A Profile by the LHPC' was published (16). The Consortium's assumptions, particularly that the pattern of patient flows would remain constant, tended to reduce the scale of change which would otherwise have been calculated for the inner-London teaching Districts and Areas. A major limitation in the LHPC analysis was the failure to consider resource consequences and implications for resource allocation policy, which is a crucial issue in London.

The second main report from the LHPC (17) was published at the same time as the Flowers Report. Two factors are central to the conclusions reached. First, the target bed allocations for each health District established in the LHPC's first report. Second, the level of hospital services required to support the pattern of medical education established in the Flowers report. It is important to note that the Flowers Working Party, and consequently the LHPC, accepted the Todd formula of ten beds per student without any appraisal of this simple, but very significant, assumption. Thus, given bed calculations produced by the LHPC, and the pattern of teaching hospitals suggested by Flowers, the LHPC then reconciled the two by identifying which existing hospitals could meet the projected requirements. In view of the assumptions used, particularly about constant patterns of patient flow and constant student intake sizes, it was not surprising that LHPC concluded that acute bed provision should be concentrated in the inner-London teaching hospitals and other major acute hospitals, leaving a number of smaller hospitals to be closed. If the teaching institutions ever felt threatened, surely their position is now secured.

6. Strategic plans — the Provincial Regions

The Provincial Regions do not have problems as extreme as those of the Thames Regions, yet many of the features which characterise planning in the Thames Regions are evident in the strategic plans of the Provincial Regions. Planning for the acute hospital sector continues to be an important aspect. The plans for the so-called priority groups (mental handicap, mental illness, the elderly) are viewed with different urgency in different Regions, and again are often consequent upon the resource requirements of the acute sector. Further, plans for these groups are constrained by the separation of services between different administrative bureaucracies in the NHS and Local Government, with all that such separation implies. Planning methodology centres on the use of various norms of provision applied to arbitrary definitions of populations. The practical consequences of plans in financial, manpower and other logistical terms are generally inadequately assessed.

Our examination of the Provincial Plans is not exhaustive. We concentrate on points of difference in approach, and particular innovations, which together give a more complete picture of strategic planning in the NHS as well as a flavour of the way in which services are being developed.

Populations

All plans make use of the OPCS projections as a basic source of data on the size of populations. The data are invariably used as absolute values with no explicit mention of the inherent assumptions about mortality, fertility, and migration, except, however, for frequent reference to the notorious uncertainty surrounding the predictions of future birth rates - a significant feature in the planning of maternity services given the OPCS prediction of a 'bulge' in the numbers of births beginning in the early 1980s. Many Regions consider the social demography of their populations in some detail, and though significant Region-wide variations in different characteristics are often demonstrated, almost invariably (with the notable exception of Standardised Mortality Ratios) these have no bearing on the planned disposition of resources. For example, the East Anglian Region states that:

> Examination of sickness certificates and self-reported acute illness in the General Household Survey indicates that East Anglia may have a population that is amongst the healthiest in respect of acute illness.

And the Northern Region states that:

> the Region (is) bleak in terms of most indicators of socio-economic deprivation ...
>
> these social and economic characteristics of the Region have created an environment which is again detrimental to the health of the Region's population.

But both Regions use the same norm for acute services of 2.8 beds per 1000 population; in fact, ignoring the provision of Regional specialties, the Northern Region uses a smaller norm of 2.3 as opposed to East Anglia's 2.5. Similarly, attention is often drawn to variations in perinatal mortality rates. But, whilst the causes of these variations are not fully understood, no real account of them is taken in determining the level or location of maternity services. Only a few Regions attempt to take account of the different needs of different poulations by weighting crude populations with Standardised Mortality Ratios (SMRs). The impetus for this adjustment originates from the fact that SMRs are used in setting financial targets for Areas and Districts; including them also in general planning calculations ensures some compatibility between financial allocation and service planning methods. One or two Regions propose to weight crude populations for their age and sex structures on the grounds that different groups make different per capita demands on services. Some Regions take account of these two factors by weighting their norms rather than the populations to which the norms are applied.

A range of different approaches is evident when the basic population data are transformed for planning purposes. Most Regions use different populations for planning different groups of services: general acute, the elderly, mental handicap and mental illness, maternity, regional specialties, and primary care and community services. It is difficult to avoid the conclusion, however, that the delineation of the formal administrative boundaries is the most significant consideration, and that different patterns of service would have resulted if the boundaries had been drawn differently.

The range in approach for general acute services varies from the use of projected resident populations to the use of current catchment patterns applied to future populations. In some instances, calculations are performed on an Area basis, in others on a District basis. Some Regions differentiate planning populations by specialty, others treat the general acute services as one group. Where individual specialties have been considered separately, the analysis points to considerable variations in population flows in different specialties; indeed, there is no justification for the assumption that flows should be equal in all acute specialties (an inherent assumption when the acute services are treated as one group), particularly when the assumption is not tested against available data. The choice of approach often appears unrelated to abstract concepts such as 'equality of opportunity of access', as stressed in DHSS guidance.

A more thoughtful approach adopted by several Regions is to estimate current population flows and then to assess how these patterns will be altered by planned developments, such as major hospital developments - though this raises the obvious question:

on what basis were the plans determined in the first place? The most notable innovation is made by the North Western Region which attempts explicitly to translate the concept of 'equality of opportunity of access' into practical terms. Networks of public and private transport routes have been constructed, and using the basic assumption that patients will go or be referred to the hospital which is 'nearest' (i.e. the shortest travelling time), 'natural catchment populations' for a given pattern of hospital services can be defined. Inherent in the method are assumptions about travelling times, the proportions travelling by public or private means, and that all patient attendances are given equal weight independent of the severity of their condition. But perhaps the most fundamental observation on the approach is that made by Forsyth and Varley (1) who have undertaken a survey of GPs' referral habits in the Manchester area and have noted: 'the small part played by ease of transport in referral decisions'. Indeed, no Region attempts to quantify, or even identify, GP referral patterns which ultimately might be the most relevant consideration for future patient flows. Nevertheless, the North Western approach is an interesting basis for further development which, in contrast to the approaches of some Regions, seems to make unambiguous and explicit assumptions in determining the basis for its planning, and the model developed readily allows the examination of alternative assumptions or patterns of service.

Services for the elderly are generally based on the formal District resident populations. For mental handicap and mental illness services, some Regions used District resident populations as the basis for estimating service requirements on the grounds that it is policy to develop community orientated care for these patient groups. Other Regions refer to the fact that current catchment areas are determined by the historical location of large institutions, and since only partial progress towards a locally based service will be possible during the strategic planning decade, the planning populations continue to be influenced by those large institutions which will remain. The North Western Region uses resident populations to determine mental handicap and elderly severe mentally infirm services, and for the 'longer stay' elements of hospital services for geriatrics and psychiatry (judged to be 50 percent and 25 percent of the total provision respectively), the other planning populations being based on travelling times, as described above. For maternity services, most Regions favour the use of projected numbers of births to District resident populations; some Regions base plans on the current catchment flows. Plans for Regional specialties, by their very nature, are less related to concepts such as equality of opportunity of access, but depend on judgements about what constitutes viable sized units and on the location of current facilities.

Determination of Needs and Appropriate Levels of Services

Acute Hospital Services

All Regions distinguish between locally (i.e. District) based acute services and Regional specialties; some Regions include

additional designation of sub-Regional and supra-Regional specialties. These classifications are not absolute, the classifications varying from Region to Region.

Basic Acute

The general approach adopted for the locally based acute services is to apply a norm, or a set of norms, to the previously defined planning populations. A range of different calculations is however evident. For example, the Oxford Region uses a norm of 2.4 beds per 1000 population applied to District planning populations modified by the District SMR (i.e. an SMR of 1.1 would give a 10 percent increased bed allocation; the District SMRs relate to a value of 1 for the Region). A similar approach is evident in the North Western Region which uses a norm of 2.515 modified for local SMRs, and additionally for different age and sex distributions in the planning populations. The Mersey Region uses a norm of 2.05 beds/1000 population, though indicates its intention in future to take account of variations in age and sex structures and SMRs in local populations. Both the Northern and East Anglian Regions begin with norms of 2.8 beds/1000 population for all acute services; the Northern Region subtracts 0.5 for regional specialties, whereas East Anglia subtracts 0.3. The Wessex Plan recognises the fact that per capita demands for acute services vary between different age and sex groups of populations and also between specialties. Thus, composite norms reflecting these factors have been derived specifically for each District. A similar approach is advocated by the Trent Region in a paper issued for consultation within the Region (2), also reported in the British Medical Journal (3). This analysis indicated the need for significant changes in the resources required by particular specialties which fall within the acute category, as summarised in table 1. This is a feature which is likely to be overlooked by those Regions which do not differentiate their calculations by specialty. The evidence of the analysis undertaken in Wessex and Trent points to the importance of taking into account differences in population structure and the effect this can have on the calculated bed requirements for different specialties.

The use of norms is not as straightforward as it might seem. In the first place some Regions make specific allowances for teaching - for example, Oxford allows 25 extra beds in its teaching Area; the North Western Region makes very substantial allowances in its two teaching Areas, one of which (the Manchester AHA (T)) is shown as having bed provision at a level about 50 percent in excess of its theoretical requirement at the end of the decade; (and the Northern Region increased the population of one of its Areas by 40,000 'for teaching'). The Oxford plan, in reconciling its bed norms to the existing bed stock, indicates that a GP bed in a peripheral hospital is counted as two-thirds of a bed. Several Regions indicate that certain Districts and Areas have used alternative methods to those proposed. The East Anglian plan states: 'Area proposals have not been presented in a standard pattern and there is consequently some difficulty in condensing the commentaries to provide a comparative basis'. The North Western Region notes that Area proposals would result in an excess of 2600 beds

Table 1
Comparison of Bed Requirements in 1988 with Current Norms in the Trent Region (beds /1000 population)

Specialty Group	Proposed Requirement	Current Norm
Medical	0.88	0.79
ENT	0.06	0.12
General Surgical	0.69	0.66
Trauma & Orthopaedic	0.55	0.44
Gynaecology	0.24	0.25
Ophthalmology	0.06	0.09
Paediatrics	0.10	0.15
TOTAL	2.58	2.50

which is considered 'unacceptable'. The Oxford Region points to the fact that several Areas and Districts have used the wrong factors in the calculation of bed requirements (the use of nationally rather than Regionally based SMRs, the omission of SMRs from a calculation, and the use of different population data).

The West Midlands plan incorporates a distinctive approach towards planning basic acute services. The first stage is an analysis to assess the changing demand (measured in terms of numbers of cases) caused by the changing population structure, assuming current rates of hospital usage. Next, using current demand as a proxy for accessibility and overall SMRs as a proxy for morbidity in each District, a graph of accessibility versus morbidity is constructed for a given specialty. A high access rate with a low morbidity is judged to be an oversupply of services whereas a high morbidity with a low access rate is judged to be an undersupply. The judgement of what constitutes a 'high' or 'low' value is made in relation to the Regional average and is not, therefore, absolute. For those Districts judged to have an undersupply of services, the number of extra cases implied by increasing the access rate to a desirable level is calculated. No action is taken for those Districts judged to be oversupplied. The total number of cases thus calculated is then converted to equivalent numbers of beds using assumptions about length of stay and patient throughput rates (discharges per bed per annum). Judgements are then made about patient flows between Districts to determine where the beds calculated should actually be located. These calculations indicate the extent of changes in provision which are required which form the basis, along with judgements about the need to replace hospital stock, for determining capital development priorities.

Most Regions support the development of day care services on the assumption that this will offset the burden placed on inpatient

Table 2

Designated Regional Specialities According to Regional Strategic Plans (Some specialities at particular units only)

Specialty	Northern	North West	Mersey	Yorkshire	Trent	West Midlands	East Anglia	Oxford	Wessex	South West	N.E. Thames	N.W. Thames	S.E. Thames	S.W. Thames
Dentistry (orthodontics)	X	X	X											
Dermatology	X	X				X								
Opthalmology	X		X			X								
ENT	X		X											
Venereology	X					X								
Cardiology	X	X	X		X	X	X	X			X			
Thoracic Surgery	X	X	X	X	X	X	X	X	X	X	X		X	
Neurology	X	X	X	X	X	X	X	X	X		X		X	
Neurosurgery	X	X	X	X	X	X	X	X		X	X		X	
Plastic Surgery (& burns)	X	X	X	X	X	X	X	X	X	X	X		X	
Radiotherapy	X		X	X	X	X	X	X	X	X	X		X	
Oncology	X	X	X		X	X			X	X	X			
Urology	X													
Audiology	X						X		X					
Haemodialysis	X		X	X	X		X				X		X	
Haemophilia	X				X		X		X		X			
Nephrology		X	X	X	X	X			X	X	X		X	
Infectious Diseases	X	X	X		X	X	X			X	X			
Smallpox		X												
Haematology		X	X			X	X							
Genetics (cytogenetics)		X			X		X		X					
Orthopaedics	X													
Neonatal (Paed.) Surgery		X	X		X				X					
Rheumatology		X												
Terminal Care		X						X	X					
Blood Transfusion					X									

Phenylkentonuria				X						
Fetoproteins				X						
Congential Hypothyroidism				X						
Choriocarcinoma				X						
Adolescent Psychiatry	X							X		X
Alcoholism (Drugs)	X									
Auxology	X									
Nuclear Medicine	X					X		X		
Radiological Protection	X									
Younger Disabled	X									
Cancer Registry	X									
Forensic Psychiatry						X		X		
Laboratory Services						X				
Neonatal Intensive Care						X				X
Pharmaceutical Services						X				
Retina Service						X				
Transplant Surgery						X				
Rehabilitation							X	X		
T & O (Metabolic)							X			
Spinal Injuries	X			X			X			
Pain Relief							X			
Endocrine Lab. Services								X		
Operating Dept.								X		
Assistants School								X		
Teaching Media								X		
Library Service								X		
Immunology								X		
Physics Service				X				X		
Artificial Insemination								X		
Medium Secure		X		X						
Tropical Diseases										X
Chest X-ray				X						X
Human Growth				X						

care. The forms of treatment for which day care is appropriate and criteria to determine the level to which services should be developed are not, however, established. Indeed, despite general exhortations there is an absence of any firm plans. Out-patient services are seldom even mentioned, though analysis has shown (4) that a direct relationship exists between corresponding in- and out-patient services, and many Regions are proposing substantial changes in in-patient provision.

Regional Specialties

All Regions consider a range of specialties which because of their sophisticated nature, and the relatively small demand for them, are provided in only a few centres. No objective criteria are established in any plan to determine what service constitutes a Regional specialty. The designation of a Regional specialty has some significance for a District, since that service is funded as a prior commitment on the Region's revenue budget in addition to the basic allocation set for the District. Thus, some competition for Regional specialty status is evident. The Regional plans indicate considerable variety in the definition of Regional specialties, as shown in table 2. Decisions seem more to reflect existing provision and what constitutes a viable sized unit, rather than any quantitive assessment of need or accessibility. This position reflects the fact that many such services exist because of the interests and enthusiasm of particular clinicians. With the increasing trend towards greater specialisation as modern medical care becomes more technically sophisticated, the pressure to recognise services as Regional specialties is bound to increase. The recognition of such services for special funding (often on the advice of medical committees) can only be at the expense of basic services at a time of constrained total resources. Competing claims on resources cannot be assessed in a comprehensive fashion, if increasingly funds are earmarked for specialist services at the Regional level which lacks the discipline of having to meet all local demands from a finite budget.

Primary Care and Prevention

Many Regions refer to the uneven distribution of family practitioner services but point to the fact that such services are outside their direct influence, and that the budgets are not subject to the rigours of cash limits, being held by the DHSS and administered by Family Practitioner Committees at Area level. Despite this, several Regions hope to be able to influence matters indirectly by providing improved facilities and support. For general practitioner services the provision of capital for health centre developments, better access to hospital diagnostic facilities, the promotion of the primary care team concept allied to the increased provision of community nursing staff, and an increased emphasis on general practice as part of the undergraduate medical training, are some of the common approaches proposed. The fact remains, however, that none of these measures can have any guaran-

teed effect where the need is most pressing, a position stemming from the independent contractor status of the GP. The problems of planning dental services are compounded by the disjointed nature of the services: the hospital dental service; the community dental services for expectant mothers, children and the handicapped; the services provided by the independent contractors. Seldom are the services provided by pharmacists and opticians in contract to the Family Practitioner Committees considered.

All Regions state a commitment to preventive services. Some Regions, however, acknowledge that many states of ill health are associated with individual behaviour (e.g. diet, smoking, exercise) or with environmental factors (e.g. pollution, poor housing) which are outside the influence of the NHS. Despite this, the NHS has an unambiguous interest in the prevention of disease and the promotion of good health, and the community physicians and health education officers are relied on to provide the necessary thrust. Some Regions feel that the problems are essentially of changing attitudes rather than resources, but despite this there appears to be an absence of new proposals for preventive programmes. Screening for specific conditions, fluoridisation, and vaccination and immunisation remain the popular approaches.

Service for the Elderly

All Regions draw attention to the growing demands which will be caused by the very elderly (over 75). Many Regions stress the need for a joint approach with Local Authority housing and social services towards the planning and provision of care, but firm proposals are absent and many Regions place unfounded reliance on the joint planning and financing mechanisms at Area level to provide the necessary impetus. Several Regions analyse the pattern of Local Authority provision drawing particular attention to the large variations in levels of personal social services in different Authorities which consistently fall short of nationally identified standards. With the increased constraints on Local Government spending the outlook is not good. Inevitably, shortcomings in other services throw a burden on health services, and elderly people are accommodated in inappropriate forms of care. As the North Western plan states:

> It is....evident that there are great difficulties in preparing rational plans for the elderly because of the dichotomy of the health and appropriate personal social services particularly arising from the very different methods of funding, and there is also evidence of a wasteful use of hospital resources in caring for patients who, given the appropriate local authority provision, could be cared for in the community.

Despite the evidence of the variations in Local Authority provision, and the outlook for the foreseeable future, no Region varies its planned levels of service to reflect that situaton. It might be argued that it is inappropriate to do so particularly since the NHS would receive no additional finance for such ser-

vices, and providing NHS services would relieve Local Authorities from meeting their obligations; on the other hand, the future demands and realities seem all too evident. Without exception, no mention is made of the services provided by the voluntary and private sectors.

The planning of health services for the elderly appears to labour under the arbitrary distinction drawn between 'acute' and 'geriatric' services. As the South Western Plan points out: 'at least 50 percent of acute facilities in this Region are occupied by the elderly (i.e. those over 65 years of age) for acute purposes'. This is a position reflected throughout the NHS. The Mersey Plan, in discussing its plans for orthopaedics, seeks to establish the necessary sequence of decisions by which the appropriate place of discharge for the elderly is chosen to avoid inappropriate location and inefficient use of resources. Despite occasional recognition of the overlap, the planning of services for the elderly is generally distinguished from the planning of acute services whereas a close relationship is in practice essen-

Table 3
Planning Norms for the Elderly

Region	Beds		Day Places	
	Geriatric	ESMI	Geriatric	ESMI
Northern	10/1000 65+	2.5–3/1000 65+	2/1000 65+	2–3/1000 65+
North West	10/1000 65+	3/1000 65+	2/1000 65+	3/1000 65+
Mersey	10/1000 65+	2.5–3/1000 65+	2/1000 65+	2–3/1000 65+
Yorkshire	10/1000 65+	2–3/1000 65+ x	2/1000 65+	2–3/1000 65+
Trent	10/1000 65+	3/1000 65+	2/1000 65+	3/1000 65+
West Midlands	(3.55/1000 65–74 (22.42/1000 75+	2.5/1000 65+	2/1000 65+	2–3/1000 65+
East Anglia	10/1000 65+	2.75/1000 65+	2/1000 65+	2.5/1000 65+
Oxford+	(3.1/1000 65–74 (20/1000 75+	5/1000 65+	2/1000 65+	2.5/1000 65+
Wessex	*7.3–8.8/1000 65+	2.75/1000 65+	2.7/1000 65+	2.5/1000 65+
South West	No norms stated in the Plan			

* age and sex adjusted District specifically

\+ subsequently revised down to:
(2.8/1000 65–74, 3/1000 65+, about 1.5/1000 65+, 1.9/1000 65+
(18/1000 75+

x plus 10–20 beds/250,000 total population for joint geriatric and psychiatric assessment.

tial (5). As has been discussed previously, several Regions determine future levels of acute services using norms which take no account of the changing population structure despite the fact that the demand and usage of such services is highly age dependent (4).

A range of norms are used to determine future levels of geriatric and elderly severe mentally infirm (ESMI) in-patient and day services, as summarised in table 3. All but three Regions use the DHSS norm of 10 geriatric beds/1000 population which pre-dates the 1962 Hospital Plan when population structures were very different. Those Regions which use age specific norms do so in recognition of the inadequacy of the traditional DHSS norm. For the other services the DHSS promulgated norms are generally used. From the evidence quoted in the Regions' plans there would seem to be cause to question the basis of the DHSS norms which do not reflect the different age structure of populations aged over 65 nor reflect the varied pattern of complementary Local Authority services. Setting appropriate levels of provision, however, might not ensure the necessary services. As the South Western plan states: 'this Region has the lowest number of consultants in this specialty (geriatrics) per head of population and it will be difficult to effect any real improvements in geriatric services, particularly in the community, without more consultant posts'. This is a problem throughout the NHS.

A policy to care for the elderly in the community where possible seems unexceptional. Yet, the plans for preventive, assessment, and community support services seem less definite than those for hospital services. In this respect, the personal social services, voluntary services, and the General Practitioner all have important contributions to make and thus the responsibility for planning such services is diffuse and lacking in co-ordination. Plans which profess the intention to increase community nursing staff have something of a hollow ring at a time when the NHS is in a period of constrained financial resources, and since such services have never been able to exert the same pull on what resources do exist as have other sectors of the health service.

Services for the Younger Physically Disabled

Many Regions consider the needs of the younger physically handicapped, and the forms of service which the NHS can provide in general terms. Such services include: community nursing, special opthalmic and ENT services, screening for visual and auditory handicap, and short stay hospital accommodation for rehabilitation and to relieve relatives. Some plans also mention the contribution which preventive measures during ante-natal care can make in reducing handicap. But the problems of identifying the needs for such services are reflected in the absence of established standards of provision, and also on occasions in the absence of any firm proposals in Area plans. The Northern Region is not alone in observing that information on the current provision of services indicates markedly different practices throughout the Region to the extent that existing data offer little guidance on the levels of service required. The Region also notes that: 'in general the AHAs do not regard the development of services for the young

physically disabled as high among their priorities for the next ten years and few of them have plans to improve existing services'. The West Midlands plan acknowledges the need for a joint approach to planning and provision of services, but states that: 'As the NHS has no control over the Local Authority planning mechanism, (the Region's) strategy must essentially confine itself to hospital development ...'. In planning levels of provision the Region notes that there are no established national criteria but proposes to use a norm of 12-18 beds/100,000 total population based on empirical studies, and indicates a range of developments in each District which would move towards meeting the current shortfalls. The East Anglian plan uses a norm of 6 beds/100,000 population aged 16-64 and points to several schemes distributed throughout the Region to meet the proposed norm. Such specific proposals are, however, notably absent in many other Plans.

Services for the Mentally Ill

There is a general endorsement of the principles embodied in the 1975 White Paper Better Services for the Mentally III (5) which proposed local (District based) provision. Standards of provision for such a service were established in that document, but as the Northern Plan points out: 'guidelines from the Department of Health on the levels of provision needed for a district mental illness service are available, but the Department has pointed out that these have not generally been derived from experience of a comprehensive mental illness service'. Despite the general acceptance of the principle of a locally based community orientated service, there is some variation between Regions in terms of the pace with which such a policy will be implemented, a feature arising out of the problems of moving from the large institutional pattern of service and the 'disposal' of 'old-long-stay' patients. Caring for mentally ill people in the community relies heavily on Local Authority housing and social services, and on primary care (the North Western Region estimates as many as 10 percent of all GP consultations - 250,000 in that Region - may result from some form of psychiatric disorder). With regards Local Authority provision, there are significant current variations evident in the levels of services provided. Some Regions point to the possibility of using joint financing monies to help to redress the shortfalls, but it is important to note that under the rules as they exist at the moment joint finance cannot be used for sheltered housing schemes. This is a consideration relevant also for plans for other groups such as the elderly and the mentally handicapped.

Over the strategic decade some Regions propose to move towards a District based service, other Regions indicate that this transition will only be possible over a much longer timescale (for example, 20-25 years in East Anglia) and that some of the large institutions will need to be retained throughout this period. In planning the level of inpatient facilities required, three component elements are generally considered - 'acute short stay'; 'new long stay'; and 'old long stay'. Estimates of the requirements of the first category vary from 0.35 beds/1000 population in Wessex; to 0.5 beds/1000 population in West Midlands; for new long stay

estimates vary between 0.17 beds/1000 population in East Anglia and West Midlands, to 0.33 beds/1000 population (possible even as high as 0.5 beds/1000 population) in the South Western Plan. Estimates for the 'old long stay element' are not generally included, the level depending on the current number resident in institutions, which is progressively reducing. For day place provision, the national norm of 0.65 places/1000 population is generally used, though the North Western Region proposes an alternative norm of 1 place for each inpatient plus 0.33 places/1000 population for non-residents, and the Oxford Region proposes a lower norm of 0.44 places/1000 population because of resource constraints. The use of such norms appears to be notional, for there is a general absence of firm proposals for action, and thus it is difficult to form a picture of what will be achieved over the decade.

Services for the Mentally Handicapped

There is general endorsement of principles embodied in the 1971 White Paper Better Services for the Mentally Handicapped (6) for moving towards a locally based service with emphasis on community services rather than hospital care. But several Regions indicate that the transition towards such a pattern of services will be slow, if anything slower than the pace of change possible for mental illness services. Several Regions point to the need for a co-ordinated approach with Local Authorities and there is an endorsement of the proposal to establish community teams for mental handicap as proposed by the National Development Group. Yet some Regions point to the varied pattern of Local authority services; as the West Midlands plan states:

> Though Local Authorities have built many schools, adult training centres and hostels for the mentally handicapped since the Mental Health Act 1959, there are still too few places in many areas. In the strategy period social services and education departments will need to provide more adequately for those mentally handicapped people who do not require nursing or medical care. The health services will then be able to concentrate on the severely handicapped, on those with multiple handicaps, and those with behaviour problems.

The West Midlands plan goes on to request guidance from the DHSS on: 'How should health services in the region respond to the local authorities' resource stagnation?' Several Regions express the hope that joint financing monies will be used to provide more social service facilities.

A range of norms are used. Most Regions favour the national norm of 0.68 beds/1000 popultion (0.55 for adults, 0.13 for children) to calculate bed requirements. For day place provision, they vary between 0.16 places/1000 population (0.1 for adults, 0.06 for children) in use in the North Western and Oxford plans, to 0.58 places/1000 population (0.45 for adults, 0.13 for children) used in the East Anglian plan, though several Regions specify no standards. The use of norms to produce firm proposals for action varies within the Districts and Areas of each Region, and it is diff-

icult to assess precisely what in fact the Regions plan to achieve. We suspect that some Regions do not themselves know.

Maternity Services

Most Regions point to the uncertainty about future numbers of births which form the essential basis for planning maternity services. Some Regions emphasise the need for flexibility. As has already been pointed out, however, the track-record of the NHS responding to changes in the birth rate is not a successful one (7), though probably the Regions are now envisaging the need to be flexible upwards (given the OPCS projections) which should prove easier than being flexible downwards.

A variety of assumptions are evident concerning numbers of births, hospital confinement rate, and resources necessary to accommodate the demand. Some Regions use the OPCS projections of the numbers of births, which incorporates the long-awaited significant up-turn (as high as 50 percent increase in some Regions). The Wessex Region assumes 12.5 births/1000 women of child bearing age as its basis. Provision for hospital confinement varies between 100 percent in many Regions, to 97.5 percent in Wessex, and as low as 95 percent in West Midlands. Estimates of the resources required vary from 32.8 beds/1000 total births in the Northern Region, to 23.3 beds/1000 live births in the Oxford Region, with other Regions dispersed within this range. Various combinations of length of stay and bed occupancy are quoted as the basis for the chosen norm, though some Regions give no indication of the implicit assumptions. In general, the proposed disposition of hospital services is in consultant units incorporating where appropriate GP beds, and the tendency is away from isolated single specialty (GP maternity) hospitals.

Several Regions stress the need to improve the early take up of ante-natal services which is seen as an important preventive measure. Some Regions refer to the need to retain domicillary midwifery services not only to provide home support for hospital deliveries, but also for the few numbers of babies delivered at home - though with the reducing demand for such a service, its viability must surely be called into question. There is some reason to believe that a policy of 100 percent hospital confinement reflects more the wishes of obstetricians seeking to make use of existing hospital facilities than the real needs of the majority of women (8). It has been argued that the specialised and high cost facilities of consultant obstetric units are not needed for many low-risk normal pregnancies (9).

Services for Children

Services for children span different forms of care provided by different agencies. As the Northern plan states in pointing out the roles of different agencies and individuals: 'There continues to be uncertainty - and a sense of potential, if not actual, confusion to parents and children - in present arrangements for medical care and surveillance of children'. Services for children in-

clude: pre-school, and school medical and nursing services; health visiting; and the care of children in hospital. They involve the effective cooperation between health, social work and educational authorities, as well as between different professionals within their respective organisations. There is a general endorsement of the Report of the Court Committee published in 1976 which emphasised the need for an integrated service and stimulated some debate on factors affecting perinatal and infant mortality, on the preventive aspects of children's services, and on the changing pattern of the needs of children, with chronic illness and handicap and psychiatric disorders assuming increased significance.

Several plans discuss perinatal and infant mortality rates and state the unexceptionable aim to reduce those rates. The factors resulting in the varying rates are not, however, fully understood - or even discussed in many plans - and, thus, despite the general intention, specific programmes of action aimed at reducing mortality rates are not always described. Only the West Midlands plan considers the variations in mortality and morbidity rates and their relationship with socio-demographic factors in any detail. This leads to the identification of 'the high level of infant mortality and handicap deriving from socio-economic rather than specifically health conditions ...' as a key issue on which 'the NHS can achieve some improvement through medical policies but other social services are involved'. Further, there is a need to 'strengthen the links between obstetrics and paediatrics specialties from health education, genetic counselling and family planning through to the birth of the child and post-natal care', a topic not touched on in many other plans.

There is a general agreement of the need for screening programmes both during pregnancy and in pre-school years, to identify, prevent or treat specific forms of handicap. During or before pregnancy, the responsibility falls clearly on the health services, in particular the development of genetic counselling and family planning services and the technologically sophisticated screening methods such as ultra-sound and amniocentesis. During pre-school and school years, responsibility is shared between hospital and community and primary care health services, as well as the services of the social service and education authorities. Proposals to develop integrated services are less specific than those for which the responsibility clearly rests with the health service.

Associated Levels of Provision in Complementary Services

In considering the substance of the plans of the Thames Regions, we referred to the evaluation of appropriate levels of services required to support the provision of the basic services. A similar position is evident in the plans of the Provincial Regions. Where support services have been considered, it has been in general terms difficult to relate to the often substantial changes proposed in basic services. Almost invariably the resource consequences of support services are not mentioned.

Assessing Feasibility

All Regions point to the significance of financial constraints on their planning aspirations. There are three stages relevant to financial planning: first, determining the likely total availability of resources; second, costing planning proposals; third, determining allocations to lower administrative levels and ultimately to budget holders.

In previous chapters we have referred to the general uncertainties surrounding the forecasting of public expenditure and the problems caused by inadequate allowances for pay and price inflation in setting cash limits. These considerations gave a broad indication of the total resource availability for the NHS in the first few years of the strategic decade, which was supplemented by DHSS guidance covering the whole ten year period which gave a range within which plans should be prepared. Given an estimate of the total resources for the NHS, assumptions are then required about its distribution to Regions. During the period within which the NHS planning system evolved, the RAWP methodology for determining target allocations for Regions was being developed. What began as a process for the redistribution of NHS resources, resulted in a process of 'levelling-up' using 'growth' money - perhaps this was inevitable given that setting cash limits for Regions is essentially a political decision, and real cuts in health expenditure are politically unpalatable. Cash limits are revised each year which inevitably creates uncertainty about the pace at which RAWP targets can be achieved. The East Anglia Plan puts forward a compelling case for accelerating the pace towards targets particularly in the light of the Region's large forecast increase in population, a case echoed, though in less forceful terms, in the other 'RAWP-gaining' Regions. Given the uncertain background, it should not be surprising to note that different assumptions have been made to forecast future resource availability in different plans. The East Anglia plan also makes the telling point that, according to the format of the NHS Planning System, Regional plans should rely on Area strategies for their substance; but the Area plans were based on resource assumptions thought to be relevant at the time they were produced, which have changed during the period when the Regional plan was being put together; hence, a certain amount of incompatibility has resulted.

If Plans are to be tested against the resources assumed to be available then they have to be costed, a task having two parts - capital and revenue. The Regional plans indicate a wide range in the competence with which this task has been undertaken. The Oxford plan demonstrates the importance of a proper analysis since the revelation that its plans far exceeded the forecast resource availability in capital, revenue, (and manpower) terms caused the Region to revise downwards to a significant extent the norms of provision upon which the bulk of the plan was based. In the event the Region had no alternative than to retain old hospital stock which was judged to be unsuitable, and its remaining capital programme would only be feasible over a 16 year time period. In general, the quality of the costing analysis seems to be poor, a factor stemming from the inadequcy of financial information for planning purposes (11). Often, revenue costing methods are not

explicitly stated, and it seems likely that simple unit costs (e.g. average cost/bed) have generally been used. Costing capital developments has the added disadvantage that the capital schemes have to be identified - a simple truth that masks considerable difficulties if the necessary technical building and engineering works are to be costed. Experience suggests that capital works in the NHS usually take longer (and cost more) than originally anticipated, and in recognition of this, several Regions have purposefully overcommitted their capital expenditure to take account of 'slippage'. Some Regions acknowledge the limitations in their attempts at costing. The Wessex plan, which seems technically sophisticated in terms of assessing the manpower consequences of its planning proposals, uses those assessments to determine the revenue consequences of its plan, based on the fact that the highest proportion of revenue expenditure of the NHS is on staff salaries; assuming a relationship between staff costs and non-staff costs (approximately three to one), the total revenue consequences can be assessed. The South Western plan presents 'programme budgets' for care groups, though it is not stated what assumptions have been used to derive the data. In general, though some plans indicate timing for certain capital schemes, little attempt is made to establish revenue or capital spending profiles over the ten year strategic period. The West Midlands plan is the only one which consistently lists capital developments in priority order for each care group, as well as indicating on what basis the priorities were determined. It has also developed a mathematical model which, given costed capital schemes, attempts to evaluate the financial consequences of the Region's capital programme year-by-year. Revenue consequences can similarly be phased and the resulting aggregate assessed.

Given a costed plan of proven feasibility, it might appear that the allocation of financial resources had thus been determined. Yet many Regions seem mesmerised with applying RAWP formula to determine revenue allocations to Areas. The various formulae for setting allocations use different criteria than those used for general service planning. The illogicality of this approach is dawning on some Regions. For example, the Mersey plan states:

> The task remains to reconcile the criteria (used for resource allocation purposes) with those being applied for service planning purposes and their resulting impact on the capital strategy.

No doubt, more than one Region has begun work on defining an integrated approach to resource allocation and planning. Some Regions still retain the much-maligned RCCS (Revenue Consequences of Capital Schemes) method of funding, thus acknowledging the need for a direct link between revenue and capital spending.

The NHS is a highly labour intensive service, yet manpower planning is poorly developed (12). Many plans point to the absence of the necessary information and statistical models. Deficiencies in this respect must debase significantly the quality of planning. Traditionally, considerations have been largely restricted to medical manpower, a small but important part of the whole. Several plans indicate broad requirements for consultant posts highlight-

ing in particular the 'shortage specialties' for which recruitment seems unlikely. Considerations of the nursing implications of plans are generally less definite. Given turnover rates, small changes can probably be accommodated at short notice, assuming sufficient funds exist. Many plans, however, are proposing significant changes in services, and the implications of EEC regulations, shorter working weeks and changes in the training curriculum indicate that manpower planning for nursing is an urgent requirement. Manpower planning for other grades of staff is even less well developed.

An exception to this general picture is the Wessex plan. The Region has put considerable effort into pioneering the art of manpower planning in the health service. An analysis of existing staffing levels in a number of categories is related to the services which those staff provide. Judgements are then made, in the light of this information, about what constitutes an acceptable standard. Given service plans for the strategic period, and the identified staffing standards, the manpower requirements can then be assessed. The Region acknowledges that its approach is still being developed, but it points the way which other Regions might do well to follow.

PART III

RESOURCE ALLOCATION

7. Resource allocation in the NHS — the principles

Health service resources may be classified into two broad categories: first, the relatively fixed physical entities of land, buildings, and major items of equipment; second, the relatively variable and mobile physical resources such as manpower, consumables, and minor items of equipment. The only common basis upon which these various types of resource can be assessed is in terms of their monetary value, and it is financial rather than physical resources which are allocated down the organisational hierarchy of the NHS. Conventional health service accounting procedures distinguish between capital and revenue. Capital expenditure corresponds largely with fixed resources in the first category. Revenue expenditure is incurred by items in the second category, plus recurrent expenditure on the environment, for heating, lighting, rates, and maintenance. The distinction between capital and revenue is significant because they are budgeted separately, with only limited transfer between the two. Further,the methods of allocation differ at each administrative level between the DHSS and the District.

The public expenditure process by which financial allocations to Departments of State are determined has been outlined in a previous chapter. In this chapter we consider how finance is reallocated from the DHSS to Regional Health Authorities. The history of resource allocation in the NHS is traced. The policy of geographical equality is discussed, and attempts to achieve such an objective by means of financial allocations based on mathematical formulae are described. Particular attention is focussed on the proposals of the Resource Allocation Working Party (RAWP) which were implemented at the same time as the NHS planning system was being developed.

An Historical Perspective

The first decade or so following the establishment of the NHS saw little change in the geographical distribution of health services, and gross variations in levels of provision continued to exist throughout the country. Planning and funding were largely incremental activities. Allocations and budgets were determined on the basis of the maintenance of previous levels of expenditure with a supplement to reflect development. During a period of substantial growth in real expenditure such a policy was rarely questioned. Only infrequently was any attempt made to assess the size of the budget in relation to the level of service provided. Difficulties of defining and measuring levels of service were, and still are, substantial.

The development of services was largely influenced and effected by capital resources. The revenue required to meet the running costs was guaranteed through the funding mechanism of RCCS (Revenue Consequences of Capital Schemes). Capital bids were relatively unconstrained by the resources which they would commit in future years. There was little incentive to determine 'best-buys' or to consider the 'trade-off' of one service against another. Even now, the economic concept of 'opportunity cost' is little recognised by health care planners.

The criteria for the selection of capital developments by the Ministry of Health, or for smaller developments by the Regional Hospital Boards, were largely unspecified. It is unlikely that such decisions were based on a rational framework, and the influence of any equalisation policy is doubtful. On the contrary, it is likely that decisions were reached on the well-known (but inadequately documented) foundations of power, representation, and political manoeuvring. The use of epidemiological research on population characteristics and needs for different types of health care was at a primitive stage, and had little impact on health policy.

The effect of this process was the development of the health service in a series of discrete and quite sizeable steps, with inadequate overall direction and an absence of any visible national co-ordination mechanism. Thus, at the start of the 1960s the geographical disparity of resource provision was still very significant. The reduction and ultimate removal of such disparity became an explicitly stated objective via the achievement of specific levels of service represented by 'norms' of resource provision. This approach implied that the per capita provision of equal resources in different locations would necessarily give rise to equal standards of health care and health. The varying levels of efficiency with which such resources might be used in different locations, and the varying health needs of populations of different types, were not taken into consideration. The assumptions used to derive 'norms' were rarely stated explicitly.

The first widespread use of the normative approach was in the 1962 Hospital Plan (1). The norms used related to beds only, and were intended to determine capital allocations for the building programme. The effect of public expenditure cuts on the capital programme and the recognition of the inadequacies of the norms resulted in a move towards a system of explicit rationing concerned more with the distribution of resources than with the achievement of specific levels of provision. This change of approach was indicated in the Government's Green Paper in 1970 (2). Reference was made to a long-term intention to derive Area Health Authority allocations from population figures, modified to take account of demographic variables, morbidity and capital stock. The RAWP approach was clearly at an embryonic stage. In 1971, a formula (the 'Crossman Formula') was introduced to guide the geographical distribution of revenue to Regional Hospital Boards. The stated purpose of that formula was: 'the removal of inequalities of allocation in the hospital service' (3).

Each Region's target allocation was determined by three elements: population, beds, and caseload. These may be viewed as being representative of: the Region's need for hospital care (the

population component); the current supply of hospital care (the bed-stock); and, the current (met) demand for hospital care (the caseload). The three components were combined with arbitrary weighting factors of 0.5, 0.25 and 0.25 respectively. In recognition of the large Regional inequalities in funding, it was recommended that movements from existing allocations to targets should take place over a period of ten years at a uniform rate. In order to judge the relevance of the formula in relation to its stated objective, it is necessary first to examine the objective itself.

West's (4) interpretation of an equitable distribution of hospital resources is one in which:

> individuals in different regions suffering from the same medical conditions had the same opportunity of access, with the same waiting time, to the same quality of care.

The realisation of this objective through a formula to determine financial allocations is only feasible if:

> a) the formula recognises that regional populations, by virtue of social and other characteristics, have different rates of ill-health;
>
> b) the formula recognises that patients in different regions will require different patterns of resource provision to facilitate equality of access;
>
> c) the formula incorporates some means of defining quality of care and establishing a relationship between this and resource provision and, in turn, with financial provision.

An examination of the three components of the formula indicates that none of the three conditions was satisfied.

The population component was based on the forecast population of the Region, weighted by the national rates of hospital utilisation (in terms of occupied bed-days) of various age/sex groups. An allowance was then made for inter-Regional patient flows. There was no assessment of the levels of morbidity, and the consequent need for health care, in different Regions (the first condition). The bed-stock component was derived from the average number of occupied beds in the Region for the previous year, classified by specialty and weighted by estimates of national specialty costs (annual revenue expenditure per bed). The caseload component was based on the average number of cases in the previous year, again classified by specialty and weighted by estimated national specialty costs (per case).

The bed-stock and caseload components represent measures of historic supply and demand respectively and, to the extent that supply generates demand, there was an element of 'double-counting' in the formula. West (4) has demonstrated that beds and cases were highly correlated across Regions. The use of both factors simultaneously might have been justified if beds and cases were intended to represent respectively fixed and variable costs (or, alternatively, capital and revenue costs); but the use of those two factors in a formula for revenue only, and the weighting applied to

the two components, does not suggest that this was the intention. In any event, both factors reflected historic levels of resource provision and demand, and their use in determining financial allocations would have resulted in perpetuating historical geographical imbalances. They would not have contributed towards achieving equality of access (the second condition). It might be argued that the achievement of equal access would depend on the redistribution of capital resources. This raises the fundamental question of how far financial allocations, other than for specific capital projects, influence the pattern of service provision and the quality of care (the third condition).

In the absence of a formal mechanism to ensure that finance is spent in a specified manner, there can be no guarantee that any formula will lead to a desired distribution of services. A rational approach would be to link financial allocations with plans for the development or redeployment of services in accordance with health policy. A sophisticated system of planning would be required to ensure that consistency is maintained between political aims and financial allocations. (The Crossman formula attempted to link policy with finance by increasing the unit costs of services for mental illness, mental handicap, geriatrics, and the chronic sick, which reflected a desire for improvements in those specialties.) This is a most important and fundamental issue in any resource allocation process and it is considered in more detail in the following chapter.

West (4) assessed the ability of the formula to effect equalisation. He concluded that, whilst the formula is capable of achieving a state of equilibrium:

> further progress towards an equitable regional pattern of care requires both a more complex set of considerations and very much more empirical data and investigations.

He considered, however, that:

> in terms of moving towards an equitable allocation of funds, the formula is a move in the right direction, since it moves allocations from 'richer' to 'poorer' regions even though it lacks the necessary detail to achieve complete eradication of differences in funding.

Once equality had been achieved, West demonstrated that the formula may then have introduced imbalances. For example, an increase in efficiency in one Region (by treating more cases with the same bed-stock) would be 'rewarded' with an increased revenue allocation. Equilibrium would eventually be reached again, but with that Region treating more cases. Hence: 'equity suffers because of the tendency of the formula to transfer funds towards the more efficient regions'. There would be, in effect, a trade-off between equity and efficiency, but West considered that the formula: 'sacrifices equity and rewards efficiency possibly excessively'.

In conclusion, West advocated:

> a formula that removes the remaining influence of historical accidents in past performance and uses instead additional objective measures relating to the needs of each region. The

weaknesses of the present formula arise because it is only partially based on the objective needs of the region through the use of adjusted populations. The other factors depend too heavily on the practices, staff, efficiency and capital of each region to escape the consequences of historical accident.

Shortly after the publication of West's paper, further consideration of resource distribution was prompted by the administrative reorganisation of the NHS. The assessment of levels of service provision in the new statutory Authorities provided information which further highlighted geographical inequalities. The replacement below Regional level of Hospital Management Committees by Authorities with statutory responsibilities for providing health care services (including community health services previously provided by Local Authorities) for defined populations, led to resource distribution becoming an issue of even greater political and social significance.

This increase in interest in resource distribution, combined with a Labour Party policy to reduce geographical inequality, culminated in May 1975 in the appointment by the Secretary of State of a Resource Allocation Working Party (RAWP). Its terms of reference were:

> To review the arrangements for distributing NHS capital and revenue to RHAs, AHAs and Districts respectively with a view to establishing a method of securing, as soon as practicable, a pattern of distribution responsive objectively, equitably and efficiently to relative need and to make recommendations.

The Working Party gave immediate consideration to methods for allocating resources for 1976-77. In view of the tight timescale, detailed research was precluded and recommendations were restricted to modifications of the previous methods of determining allocations to Regions. The recommendations were presented in an Interim Report published in August 1975 (5). For revenue, the population and caseload components of the hospital revenue formula were retained and combined in the ratio of 3 to 1. The effect of the population or 'needs' element was thus enhanced, whilst the effect of the demand element (and indirectly historical supply) was diminished. The bed-stock element was eliminated completely. An element was introduced for community health services, assessed on the basis of weighted population. Within each Region's total allocation there was a protected teaching allowance, and RCCS was guaranteed for major capital schemes. Minimum and maximum annual growth rates (zero and 4 percent respectively) were established. Capital allocations were determined partly by existing commitments and partly by weighted forecast populations. The DHSS issued interim guidance on sub-regional allocations; as far as possible such allocations were to be made in accordance with the principles determining allocations to Regions.

The Working Party's substantive report (6) was produced in September 1976. It contained recommendations for determining capital and revenue allocations to Regions, Areas and Health Dist-

ricts. The recommendations differed substantially from those in the Interim Report and have had wide implications for all parts of the health service. They have highlighted many deficiencies in knowledge of how the NHS operates and the effect which it has on the health of the population. If nothing else, the RAWP report has stimulated an awareness of these deficiences and has prompted a great deal of thought, debate and formal research.

Recent economic trends have contributed to the interest in RAWP. A reduction in growth money has meant that equalisation could only be pursued at a slow rate. The effects of RAWP are beginning to bite quite hard in certain parts of the country, and this has led to a most vigorous scrutiny of its principles. To some extent, attention has been diverted from the fact that planned growth rates in public expenditure for the whole service have failed to materialise:

> Instead Regions are squabbling amongst themselves over their shares of an inadequate cake ..... RAWP gives the same impression as other DHSS smokescreens for deterioration or inaction (7).

During the remainder of the 1970s the RAWP recommendations were implemented by the DHSS and were adopted, with a variety of modifications, by Regions in their determination of sub-Regional allocations. It is likely that the basic principles will remain into the 1980s, and these are therefore examined in the remainder of this chapter. A critical appreciation of the RAWP recommendations can be gained by assessing the way in which they have been debated and implemented by Regional Health Authorities, and this is discussed in the following chapter.

The RAWP Principles

Methods of resource allocation in the NHS have always been based on a compromise between two elements: the maintenance of the existing level of provision, and the development of services in accordance with the needs of populations. RAWP's terms of reference - 'to establish a pattern of distribution responsive to relative need' - indicated a move away from such a compromise towards a method based solely on population criteria reflecting need. The emphasis on a 'needs-based' mechanism was confirmed in the objectives which the Working Party derived from its terms of reference:

> a. To reduce progressively, and as far as is feasible, the disparities between the different parts of the country in terms of opportunity for access to health care of people at equal risk; taking into account measures of health need and social and environmental factors which may affect the need for health care.
>
> b. in pursuance of the above, to develop criteria and indicators of health need which could be incorporated in methods (e.g. formulae) for allocating resources and, where available

> resource falls short of requirements based upon need, used in assessing the competing claims of different localities ....

The fulfilment of those objectives is conditional on two assumptions: first, that a suitable taxonomy or index of health or health care exists; second, that a population's need for different types of health care can be measured in an objective manner. The conceptual and practical difficulties of defining and measuring the need for health care are formidable, and the problems of establishing a method of allocation 'responsive objectively, equitably and efficiently to relative need' seem insurmountable. Further research into measures of health need, and the establishment of systems to measure and record it on a national scale, appear unavoidable. RAWP, however, disregarded such requirements and restricted its interest and activity simply to considering:

> only those criteria, the supporting statistical data for which are readily available and reliable at all three levels of disaggregation (i.e. region, area and district).

The ability of the Working Party to meet its fundamental objective was therefore open to question at the very outset.

The problems are even more complex than the definition of need. Ideally, an effective means of distribution according to any set of criteria concerning equality should be self-correcting, and therefore converge to a state of equilibrium. The effect of the annual allocations should be to reduce the levels of inequality as defined by the chosen criteria. In RAWP's case the fulfilment of such a requirement is conditional on the following assumptions:

> a) that the provision of health care in proportion to need will ensure that such need is met;
>
> b) that the provision of resources in the same proportions will lead to the same relative levels of provision and availability of health care;
>
> c) that the allocation of finance in the same proportions will result in the same relative levels of resources.

RAWP thus attempted to satisfy an objective defined in terms of equality of output by means of an equalisation of inputs. A positive linear relationship between inputs and outputs was implicitly assumed. The existence of a straightforward linear relationship between finance, resource levels, service levels, and health needs is extremely doubtful; much additional research is necessary to identify whether, in fact, an identifiable relationship exists between any of these factors. This consideration must cast fundamental doubt on the RAWP approach.

With the exception of a consideration of geographical variations in labour costs, the links between financial resources, physical resources and services were explicitly disregarded by RAWP:

> Resource allocation is concerned with the distribution of financial resources which are used for the provision of real

> resources. In this sense it is concerned with the means rather than the end. We have not regarded our remit as being concerned with how the resources are deployed.

The relationship between levels of resource provision and use is complex. It depends on a variety of factors such as: resource mix; resource location (in relation to population served); local administrative and clinical policies; the efficiency with which the resources are used; and, not least, the needs of the population for such resources. Indeed, as Buxton and Klein (8) have pointed out, there is a 'lack of studies of how Areas or Districts with roughly the same level of resources translate those resources into the provision of health care services'. The most significant factor in resource productivity may be the location of resources in relation to the population. For example, the costs of providing community services and of providing access to hospital services in sparsely populated areas may be extensive. (It is worth noting that SHARE(9), the Scottish equivalent of RAWP, recommended the use of a compensating factor for areas with low population density). Another factor affecting productivity could be the size of hospitals, where economies or diseconomies of scale may be evident.

The Working Party's disregard for how allocations are deployed raises the fundamental question of the relationship between the RAWP process and the planning system. The RAWP mechanism provides one input into the planning process through its use in the calculation of future resource assumptions. The implementation of plans is dependent on the way in which the RAWP calculations are applied. It would appear therefore that the criteria upon which policies for developing services are based should be consistent with the criteria used to allocate resources. But, the two sets of methods are fundamentally different. RAWP emphasised territorial equity, whereas the planning system gave prominence to policies on particular patient groups. The DHSS has made no attempt to reconcile the two approaches. The Regional plans have negligible influence on the resources allocated to them and are not seen to represent competing claims for development monies. The DHSS does not base its allocations on Regional plans, but on the RAWP mechanism. This allows Regions some room for manoeuvre since policies can be pursued which are not consistent with those of the DHSS without jeopardising allocations. At Area and District levels the need to reconcile service plans and financial allocations is more crucial, but the two processes still tend to be regarded separately.

The Working Party's interpretation of its objective in terms of:

> opportunity for access to health care for people at <u>equal risk</u> (authors' emphasis)

has the same inherent problem as the linkage between financial resources and need for health care. In this case the requirement would seem to be that there exists a measure of <u>need</u> which reflects the <u>relative risk</u> of ill-health, and that <u>financial allocations provided in relation</u> to such need will necessarily secure equal opportunity of access. There was, however, no attempt

to identify either risk or access. There was no consideration of the relative opportunity of access to health care which should be given to those people at different levels of risk. Presumably such relativities will be specified in statements of health policy - this provides further illustration of the Working Party's ready acceptance of the philosophy of independent processes for resource allocation and policy formulation. Furthermore, it was assumed that such an objective would be met by a geographical redistribution of resources. Whilst it is intuitive that access, however defined, will be partially dependent on physical proximity, other factors such as cost and availability of transport might be significant. As Buxton and Klein have suggested (8), the redistribution of physical resources is rarely a straightforward exercise, and a worthwhile alternative may well be to facilitate patient mobility by the provision of improved transport services. Whilst the viability of such an approach will clearly require much further consideration, there is no evidence that it received serious attention by the Working Party. The only notion of access in RAWP's recommendations was the adjustment for people who cross health authority boundaries for in-patient care. The underlying policy assumption, which was stated explicitly in earlier planning guidance (10), was that patients should be able to secure treatment in the Health District where they live. Thus, access would seem to have been implicitly defined in terms of the existing administrative boundaries within the NHS. In later guidance (11, 12), this policy of self-sufficiency was modified to 'equality of opportunity of access', but again without attempt at definition.

A fundamental criticism of the Working Party's Report, then, is that whilst its objective was couched in terms such as equality, opportunity, access, risk, and need, no further discussion of those concepts was presented. There was no attempt to define them in quantitative terms, yet the result of the Working Party's deliberations was based ostensibly on quantifiable criteria. It is evident, therefore, that the links between the Working Party's objective and its recommendations are somewhat tenuous. This inadequate relationship has been commented on by Cuninghame-Green (13):

> ....any document which begins by stating its objectives in terms of impalpable essences places itself at the outset on the wrong side of an invisible barrier between a metaphysical world and the world of what can be observed. It must then promptly proceed to replace all the concepts used in its objectives by others which correspond more closely to what is observable.

The RAWP Recommendations - revenue allocations to Regions

At the outset, RAWP confirmed the view expressed in the Interim Report (5) that the chief mechanism for determining allocations to Regions should be by a mathematical formula. This formula should be applied to the largest possible proportion of the national revenue budget; central Departmental reserves should be kept to an

absolute minimum. The application of the formula would determine that share of the budget which should under ideal circumstances be accorded to each Region - the Region's revenue target. The comparison of a Region's actual revenue allocation with its revenue target would then indicate whether that Region was under-provided or over-provided. Subject to certain constraints regarding maximum permissible variations, changes in allocation should take place in proportion to the distance from the target.

The revenue target is calculated from a weighted aggregate of seven component service populations, each of which is a weighted population figure deemed to be representative of the Region's 'need' for that service. The seven service categories are: non-psychiatric in-patient services, day and out-patient services, community services, mental illness services, mental handicap services, family practitioner services, and ambulance services. The weighting factors represent the historical proportion of the NHS revenue expenditure which has been spent by each service. The Family Practitioner Services component relates only to the administrative support provided by the Area Health Authorities. The services themselves are funded separately outside the RAWP process. This is an important exclusion as the services provided by general practitioners are not independent of hospital or community services, and the balance between these services is a critical consideration in health care planning.

The basis of each service population is the resident population of the Region, which is weighted to reflect the variation in demand between different age/sex groups. For certain service populations, further weights are applied to reflect mortality, fertility, marital status and other factors. Adjustments are made for patients who received treatment outside their Authority of residence. Further allowances are made for agency and for extra-territorial management arrangements, for long-stay psychiatric cases, for the extra costs of providing services in the London area, and for medical and dental teaching responsibilities.

The Population Base

The primary factor representing relative 'need' was the resident population. The most accurate assessment of a Region's population is that obtained at the decennial census. In intermediate years, the Office of Population Censuses and Surveys (OPCS) produces mid-year estimates of resident populations based on the census data and birth and death registrations, together with assessments of migration. RAWP recommended that the most recent OPCS mid-year population estimate be used. In practice, for a given financial year for which resource allocations are being determined, it is unlikely that the mid-year estimate for the immediately preceeding calendar year would be available. The most recent mid-year estimate is usually two years out of date.

Population Adjustments: inter-Regional flows

The geographical boundaries of Regions (particularly those boundaries cutting through urban areas) are such that some patients

receive care in an adjacent Region because access is more convenient or because of established referral patterns. In addition, the absence of a service in one Region leads to patients receiving care in another. The Working Party made allowance for formal agency arrangements whereby Regions manage services outside their boundaries. In the case of all other in-patients not resident in their Region of treatment, a compensatory adjustment was made. No attempt was made to distinguish between those patient movements caused by convenience and those made for necessity. Nor did it recommend that consideration be given to those patient flows which it was desirable to perpetuate as opposed to those which should be reduced.

It seems odd that an allocation method based on geographical equity should allow for the continuation of a factor indicative of geographic inequality - namely, the necessary flows of patients between Regions to receive a service not available locally. Presumably it would have been difficult to differentiate objectively between this type of patient flow and that arising through established communication patterns. But this example indicates the rigidity of the allocation mechanism. The assumption that all existing inter-Regional flows will continue may be contrary to local plans. In fact, planning guidance issued in 1978 (11) advocated a distinction between 'natural' flows and those caused by service imbalances, and it was suggested that plans should be based on the assumption that the latter flows would be removed.

The formula was also influenced by the availability of information. Data describing patient movements are available from Hospital Activity Analysis (HAA) in respect of non-psychiatric in-patients, and from the Mental Health Enquiry (MHE) in respect of psychiatric in-patients. There are no corresponding data for day- and out-patient services. The Working Party rejected the hypothesis that out-patient flow patterns correlated with in-patient flows; it was recommended that except for agency arrangements there should be no adjustment to reflect inter-Regional flows of out-patients or day-patients. For the remaining service populations (community, ambulance, and family practitioner services) it is assumed that Regions are self-sufficient. As with the population estimates, the available data from HAA and MHE generally relate to the calendar year two years before the year of allocation. Recent changes in patient flows arising from, say, major capital developments in the preceding two years, cannot therefore be accounted for.

The adjustments for non-psychiatric in-patient flows between Regions reflect the relative cost per case in different specialties. The need to recognise different costs seems obvious, but the weakness of the available cost information undermines the validity of the approach. It was recommended that following the 1974 reorganisation the NHS costing system should incorporate a tertiary analysis from which unit costs by specialty could be derived. It was evident, however, that without substantial modifications to hospital information systems it would be impossible to record the details of the resources consumed by patients in different specialties, and hence the associated costs. A substantial amount of arbitrary apportionment of costs would be necessary, as is the case currently with the secondary analysis which provides a simple

breakdown of costs between in-patients, out-patients, day-patients etc. In practice, the tertiary analysis of accounts has never taken place, although recent research in one hospital (14) has led to a prototype system which is now being tested in other locations.

In the absence of specialty costs derived by cost accounting methods, the Working Party advocated the use of costs derived from regression analysis. There are clear advantages in using cost estimates derived by such a method. They are based on available data, and the calculations are relatively simple and cheap to perform. But there are also several disadvantages. In order to obtain statistically reliable results, the individual specialties have to be grouped together, although there could be substantial variation in costs between individual specialties within the same group. The basic cost data used in the regression analysis is derived from the secondary analysis which itself is based on approximations. The regression model adopted by RAWP has also been shown to be technically flawed (15). Perhaps the most important consideration is that the use of average costs assumes that those patients seeking care outside their Region of residence receive treatment costing the same as those who do not cross the Regional boundary. With the exception of flows of convenience, however, it might be expected that those patients crossing boundaries are complex cases requiring specialised (and hence more costly) treatment. The formula may therefore be judged to discriminate against those Regions which are net importers of in-patients. Such allowances for cross boundary flows are unlikely to reflect adequately the provision of a service of supra-regional importance. The only alternative is to fund such services as a prior commitment on the NHS budget outside the routine allocation mechanism.

For the mental illness and mental handicap services, inter-Regional agency arrangements and patient flows are treated in a similar way to non-psychiatric in-patient services, although there is no attempt to reflect case-mix. An adjustment is made, however, in recognition of long-stay patients admitted many years previously whose original place of residence is rarely known. The Working Party defined long-stay patients as those whose length of stay exceeded one year when the last census of mental illness and mental handicap patients took place in 1971 and 1970 respectively, which were considered to be the base years. The actual number of long-stay patients in each Region is compared with the expected number derived from the application of national demand rates (differentiated by age and sex) to the Regional population. Actual and expected numbers of long-stay patients are derived for each Region for the base years from the census data. The Working Party suggested that actual numbers for each Region could be 'updated from the latest available data', and that expected numbers could be adjusted 'by reference to the national reduction in the numbers of such patients since the base years as revealed in these latest available data'. The source of those data was not specified; nor was it absolutely clear whether such data should refer to the same cohort of patients enumerated in the census, or whether the base year itself should move to incorporate additional cases who have been detained for more than one year. (In practice the former 'cohort' definition has been adhered to). A further adjustment was

then necessary to project the number of actual and expected cases to the year of allocation. For this purpose a constant national annual rate of decline was advocated by RAWP, but again its origin is unspecified.

The resulting surplus or deficit of long-stay patients in each Region is then weighted by the national average cost per year of long-stay cases. Again the source of the cost data was unspecified, but it appears the unit cost related to all mental illness (mental handicap) in-patients, which assumed that the per diem cost is the same for both long-stay cases and other cases. The method of aggregation of the cross-boundary component (non-cost-weighted) and the long-stay component (cost-weighted) advocated by RAWP provides an implicit cost weighting of unity to the former component. This became apparent when the RAWP method was applied sub-Regionally and negative components resulted. The DHSS has corrected this by incorporating an explicit cost weighting for cross-boundary flows, but again the source of the cost data is unclear. It would appear that it is based on a weighted aggregation of the average cost per case for all in-patients in mental illness (handicap) hospitals (i.e. including long-stay), and the average cost per case in non-psychiatric hospitals with psychiatric units.

Population Adjustments: 'need'-weightings

RAWP recognised that the composition of a population affects the need for health care. In particular, age and sex were considered to be important factors. Notwithstanding the lack of data reflecting differential need, a linear relationship between such need and demand was assumed, and it was recommended that age/sex specific utilisation rates be used as weighting factors in five of the seven service populations.

The recommended weightings were largely dependent on the availability of appropriate information. For non-psychiatric and psychiatric in-patient services, age/sex specific utilisation rates relating to hospital beds (occupied bed-days) are available from the Hospital In-Patient Enquiry (HIPE) and the Mental Health Enquiry (MHE) respectively. For day and out-patient services, it is not possible to derive utilisation rates by age and sex from routine information systems. Instead it was decided to use those relating to out-patient attendances determined over a two-week sample period by the General Household Survey. For community health services, there is again no routine source of utilisation data by age/sex groups, although details of the take-up of several individual components of the community health services by different age groups is available on a national basis. The latter information is used to apportion community health services revenue expenditure, and it was the resulting age-specific cost weightings which RAWP recommended as reflecting differences in utilisation.

The Working Party also recognised that there are many population characteristics other than age and sex which are major determinants of the need for health care, but stated that:

> even where particular factors can be seen to play a part in

> causing (sic) health need, it is often difficult to quantify the relationship and draw upon reliable information.

In particular, the influence of social and environmental factors on the need for health care was recognised, and the Working Party sought to take them into account. Explicit consideration of those factors was, however, subsequently avoided:

> except in the sense that they all have an impact on the morbidity of populations, we cannot take them into account. They are the province of other social programmes and the extent to which they react with the health care programme is not an issue with which we are equipped to deal.

The avoidance of what, to many, represent the critical factors underlying the differential needs for health care within populations, was a considerable disappointment. But the resulting criticisms of RAWP were rarely constructive. One critic (16) advocated the use of a 'conurbation factor' to allow for 'heavy concentrations of urban social deprivation'. The difficulties of defining and quantifying such a factor were implicit in the author's suggestion that 'the mathematical approach should be abandoned, and in its place there should be small review parties'. There was no indication of how such groups should operate, nor how their assessments of resource requirements for different areas would be reconciled. Though the Working Party appeared to consider some evidence of research into the relationship between social factors and health needs, it concluded that:

> whilst figures are available, for example, on relative population densities and on social class structures, we have not found it possible to relate this information quantitatively to the need for health care.

Perhaps the restriction was the consideration of need, although assumed variations in need between different age/sex groups were based on demand rates. There is an abundance of published research indicating strong connections between, say, social class and demand for different types of health care. Such research might identify several population characteristics which are significantly related to the demands for health care, but the combination of such multiple factors into an index would present difficulties.The Working Party rejected this approach because:

> factors such as occupation, poverty, social class and pollution are likely to interact in ways which are not fully understood.

Having searched in vain for factors (other than age and sex) which influence need for health care, the RAWP report then, without further discussion, equated need with morbidity. There is no evidence of any attempt to define different types of morbidity. Of particular relevance might have been those forms of morbidity which could be alleviated by the provision of health care services. Instead, nationally available statistics were re-

viewed in a search for a single overall indicator of population morbidity, independent of the supply of health care resources, and yet quantifiable and with a wide coverage. Statistics relating to sickness payments were considered first. Though available on a national basis, they were rejected because they relate only to the economically active. Sickness levels recorded in the General Household Survey (GHS) were also considered, but these are self-reported and relate to a relatively small sample which is structured in a way which is not directly comparable with administrative boundaries of health authorities. The GHS data were also rejected on the grounds that they would not be sufficiently reliable in terms of diagnostic category. As the Radical Statistics Health Group point out (7), this rejection 'only makes sense if the Working Party had already decided on the sort of method they eventually adopted, involving weighting different diagnostic groups'. The rejection of these and other surveys of morbidity led the Working Party to examine the 'possibility' of using mortality statistics 'as a proxy indicator of morbidity'. Such statistics have the advantage of full national coverage and can be structured according to residence as defined by NHS boundaries. The Working Party did not present, nor even suggest that it has considered, hard evidence of significant associations between mortality and morbidity. It appears that on the basis of a diagrammatic representation of the correlation between Regional Standardised Mortality Ratios (SMRs), (age-standardised) sickness claims, and (age and sex-standardised) self reported chronic and acute illness (from the GHS), the Working Party suggested that:

> Regional differences in morbidity explain the greater part of differential mortality and that statistics of relative differences in Regional morbidity, if they existed, would exhibit the same patterns as those of mortality.

The logic of the above analysis is very odd, since the morbidity indicators used are those already judged by the Working Party as unsuitable. (Using data relating to the ten former Regions of England and Wales, Forster (17) has since shown that the association between mortality and the morbidity data of the GHS relating to acute sickness is not very strong at all.) The lack of published information on the 'studies and analyses....supported by the findings of research in related fields' casts fundamental doubt on the credibility and validity of RAWP's assumptions.

Buxton and Klein have suggested (8) that:

> in the circumstances the question of the usefulness of SMRs might best be put in terms of whether the existence of high SMRs is likely to indicate, directly or indirectly, a need for a high level of health care.

Such an indication is far from obvious, and depends to a large extent on the nature of the underlying condition. Undoubtedly, some conditions resulting in 'early' death require the provision of substantial quantities of health care resources. On the other hand, there are a number of chronic conditions which place considerable demands on health service resources over a long period of time, but whose incidence cannot be approximated by mortality.

To a limited extent the RAWP formula recognises this. For the non-psychiatric in-patient services component, it uses SMRs specific to groups of diseases, and weights them by bed utilisation rates for these diseases. The problem here is that historic utilisation rates may well reflect historical supply factors, which may in turn depend on past health care policies. In a climate of changing priorities there may therefore be inconsistencies between priority guidance and allocated resources.

The bed-usage weighting factor will not compensate for those conditions which impose heavy demands on out-patients and community health services, and there is no condition-specific weighting within these latter components. Moreover, weighting by SMRs will fail to reflect spending on the treatment of chronic conditions. It is therefore surprising that the RAWP formula has an implicit assumption of positive linear relationships between SMRs, morbidity, and need for revenue. In fact, it is likely that different relationships exist for different conditions - for example, it might be argued that, for congenital malformations, mortality is inversely proportional to morbidity and the associated need for resources. It is interesting to note that the absence of a positive linear relationship between mortality and morbidity was recognised by the Scottish Revenue Allocation Working Party (9) in respect of the over-65s.

The relationship between mortality and morbidity will also depend on the interpretation of the cause of death. National mortality statistics used in the derivation of SMRs are based on the underlying cause of death. However, there are often associated causes of death such as diabetes (which appear on the individual death certificates but do not appear in summary form) which can give rise to significant levels of morbidity and consequent demands for health care. It might therefore be argued that for a relationship between mortality and morbidity to be defined, there has to be analysis of all the pathological circumstances surrounding the death.

The main reason for using SMRs in preference to crude death rates in comparing mortality between populations is to take account of differences in age/sex structure. RAWP recommended that SMRs should be used to reflect geographical variations in morbidity in respect of the following service populations: non-psychiatric in-patient services; out and day-patient services; community health services; and ambulance services. In respect of mental illness and mental handicap in-patient services, it was considered that 'mortality is not an appropriate measure for psychiatric morbidity'. For FPC administration it was suggested that the need for this service was not related to morbidity.

The mortality statistics were used as measures of the differential needs for in-patient services in various diagnostic conditions grouped together according to the chapter headings of the International Classsificaton of Diseases (ICD), with the following exceptions:

a) mental disorders - account is taken of the need for mental care in the mental illness and mental handicap service components.

b) conditions of pregnancy, childbirth and puerperium - mortality is very low and it is judged that a better indicator of geographical need is the Standardised Fertility Ratio (SFR).

c) diseases of the skin - mortality is very low and therefore provides a poor guide to morbidity.

It is difficult to understand why the argument in (c) above does not also apply to other ICD groups. Though the numbers of deaths in other groups are higher than for diseases of the skin, they are nevertheless sufficiently low to be subject to large random fluctuations. In fact, six of the ICD chapter groups each account for less than 1 percent of the total national deaths. An analysis of the variation of Regional SMRs for a single ICD group (18) has confirmed that large fluctuations exist. These would be further magnified if, associated with such a group, there were high bed utilisation rates. The problem is illustrated by the six groups referred to above, which together account for 3.5 percent of deaths and yet give rise to over 20 percent of all occupied bed-days. Geary (19) presented a similar viewpoint on behalf of another Region, relating 5 percent of deaths to over 25 percent of bed-usage.

A related problem arises in respect of those ICD groups which account for a large number of deaths. For example, the group containing heart and circulatory diseases accounts for over 50 percent of all national deaths. Disaggregation of these groups into individual causes of death gives rise to SMRs (and bed utilisation rates (20)) which vary widely from those for the whole group. In such cases it might be argued that the group should be disaggregated. In general, RAWP's use of the diagnostic taxonomy offered by the ICD chapter groups would seem to be governed more by convenience than by suitability.

Mortality information relating to current health authority boundaries has only existed since NHS reorganisation in 1974. When the RAWP report was published it had only been possible to calculate SMRs based on 21 months' data. The problems of statistical reliability for those ICD groups with relatively low mortality rates was recognised, and it was recommended that as time progressed data for as many years as possible (up to a maximum of ten years) should be used. No details of any analysis on which the Working Party had reached this conclusion were published, although there was a statement suggesting that a 'sensitivity test' had been used to assess the reliability of SMRs at sub-Regional level.

Palmer (21) has expressed concern that 'a seemingly objective measure such as SMRs may give a misleading impression of accuracy'. He calculated SMRs for each ICD group on mortality data covering 3 years, and assessed the implications of excluding from the RAWP calculations those Regional SMRs with deviations from the national average which were not statistically significant (i.e. they might have been due to chance). More than one half of the sex and condition-specific Regional SMRs were not different statistically from the national average. When the non-psychiatric inpatient component of each Region's target was recalculated omitting such SMRs, the average absolute change to this component of

each Region's target was just over 0.5 percent. Such changes should decline as more data become available. Palmer has estimated that for most ICD groups less than ten years' data are required to produce statistically significant SMRs, which suggests that the Working Party's recommendation of using up to ten years' data is reasonable.

There is no indication in the RAWP report that mortality indices other than SMRs were considered, although there are several which can be used to compare mortality in different Regions. One of these is the age-specific mortality ratio (ASMR) - obtained by dividing the Region's mortality rate for a given age group by the equivalent national rate. There is, in fact, a direct relationship between an SMR and the corresponding ASMRs, the SMR being a weighted aggregate of the ASMRs. The weighting factor for each ASMR is the proportion of expected deaths arising in that age group. In some cases it is possible for the SMR to conceal large variations in ASMRs. This point was supported empirically by Barr and Logan (22), who illustrated that whilst the overall SMR for Oxford RHB in 1973 was much lower than that for Newcastle RHB, for certain age groups the mortality rates were lower in Newcastle than in Oxford. It was argued that if deaths in those latter age groups were particularly significant in terms of morbidity, then morbidity is hidden in the overall SMR. In a theoretical investigation of the relationship between SMRs and ASMRs, Kilpatrick (23) concluded that large variations in ASMRs rendered the use of the corresponding SMR invalid. A statistical test of the variation of ASMRs was suggested, but there is no evidence that the Working Party performed such a check.

The relationship described above between the SMR and the corresponding ASMRs means that the value of the SMR is largely determined by the ASMRs for those aged over 65. It might be argued that deaths in other age groups provide a useful indicator of differential need for health care. It has also been suggested (24) that the determination of certified causes of death is imprecise in the case of the elderly as it is common for death to be attributable to the simultaneous onset of several pathological disorders.

The use of an SMR as a summary index is particularly useful in cases where the age distribution of actual deaths is unknown (and therefore it is not possible to calculate the ASMRs). However, from the mortality data used in RAWP the ASMRs are readily calculable and it is difficult to understand why Regional ASMRs were not used directly in the RAWP formula. The need to standardise for differences in age/sex structure would then be obviated and the formula simplified. Moreover, each age group's mortality could be linked directly to utilisation. The problem of sensitivity to random fluctuations in deaths would be increased, however, due to the smaller number of deaths from which condition-specific ASMRs would be calculated, and it is likely that this is the reason for their rejection by RAWP.

The substitution of ASMRs and other mortality indices in place of SMRs in the RAWP formula has been investigated by Palmer et al (25). The other indices examined are similar in concept to the SMR, representing linear combinations of the corresponding ASMRs, but they differ in terms of the relative weighting factors applied to each ASMR, and hence the relative importance accorded to deaths

at different ages. It was argued that some indices may be more appropriate than the SMR in terms of an assumed relationship between morbidity and mortality accross age groups, but the SMR has the greatest statistical reliability by virtue of according high weightings to those age groups with the largest number of expected deaths.

The SMR is the factor responsible for the greatest change in Regional targets. Its effect is to increase significantly the targets of those Regions in the northern half of England, and to decrease those in the south. Palmer assessed the effects of using alternative mortality indices, and found that the general direction of change was similar to that produced by the SMR, but that the magnitude of the change differed significantly from one mortality index to another and from one Region to another. This conclusion suggests that the decision by RAWP to incorporate a mortality index was no more significant than the choice of the index itself. Although other indices than the SMR are less well known, they are no harder to understand or apply within the formula, and further consideration should be given to them, since they may give a better explanation of the differential morbidity between Regions.

Population Adjustments: cost-weightings

Cost weightings by specialty groups were used to adjust the basic non-psychiatric in-patient (NPIP) component to reflect the costs of treating patients who cross administrative boundaries for in-patient care. The Working Party also recommended that cost weightings be applied to the resident population to reflect the different costs of providing in-patient care for different types of case. The structure of the NPIP component in terms of utilisation rates by age/sex/ICD group and SMRs by sex/ICD group suggests that differential costs by age/sex/ICD group would ideally be desired. However, the existing costing system does not enable the identification of in-patient costs by any of these categories, and the Working Party had little alternative at the time but to omit in-patient cost weightings from the formula. They did, however, set in motion 'a study which may enable a broad distinction between conditions requiring predominantly acute or non-acute care'. The outcome of this study is unclear, but in early 1978 Regional Administrators were notified by the DHSS (26) of the method by which Regional target allocations for 1978-79 had been calculated, and this method incorporated a cost-weighting by age/sex and ICD group, derived in the following manner. Bed utilisation rates, already defined by age/sex and ICD group, were further defined for each of fourteen hospital types from HIPE. A cost per occupied bed-day for each of the hospital types was available from the hospital cost returns. Costs by age/sex and ICD group were then derived by weighting each of the costs per occupied bed-day by the corresponding bed utilisation rate for that age/sex/ICD group and hospital type, and aggregating across the fourteen hospital types. This therefore assumes that within a hospital type the cost per occupied bed-day is the same for each age/sex group in each ICD group. This provides another example of a sub-optimal

solution being necessary because of inadequate data, and this assumption needs investigating further. In a study of the sensitivity of Regional targets to changes in the cost weightings (27), it was found that a 100 percent increase in the costs for an individual ICD group gave rise to changes of the order of 1-2 percent in some Regional targets. If higher costs were to apply to several ICD groups, however, changes in Regional targets tended to be self-cancelling, and the formula was judged to be fairly robust. The study did, however, identify those disease groups where more detailed costing might be fruitful for the purpose of future RAWP allocations.

The search for suitably classified cost data also highlights the inconsistency of building up a NPIP component from two elements, the first reflecting differential need based on age/sex/ICD group, and the second (the cross-boundary adjustment) reflecting differential need based on specialty. This is partly a reflection of data availability, but it would have been possible for the bed utilisation factor of the first element to have been based on specialty rather than ICD group, or alternatively, for the caseflow of the second element to have been classified by age, sex and ICD group. The desire to incorporate SMRs classified by ICD group seems to have been a major determinant in the classification of the first element but, as discussed above, this introduced problems when attempting to derive corresponding unit costs. The classification of the second element may well have been determined by the availability of unit cost estimates by specialty.

Further costs were introduced into the formula as weighting factors in the aggregation of the seven different service populations. The weightings represented the historical percentages of national revenue expenditure accorded to each service. Approximations were necessary when determining the costs of mental handicap and mental illness services. The identification of the costs of providing psychiatric in-patient services in non-psychiatric hospitals is not possible, and average costs for these hospitals were assumed to apply to the psychiatric cases.

Whilst RAWP had consciously ignored any link between policy and resource allocation, the use of service population weightings may be considered equivalent to a statement of priorities. Creese (28) was particularly critical of the opportunity ignored by RAWP to establish a link with health care planning. A possible explanation was that the programme budget classification used in DHSS planning guidance was not directly compatible with the service components of the RAWP targets. However, Creese attempted to alter the weightings in the RAWP calculations to reflect planning guidance. The results served to illustrate a lack of sensitivity of the formula to changes in these weightings, but the authors still advocate the approach as 'a step towards overcoming the arbitrary separation of planning from resource allocation in the NHS'.

RAWP gave serious consideration to the introduction of cost weightings to reflect the geographical variations in the cost of providing equivalent services. For non-staff costs (e.g. supplies, heating, lighting) it is unlikely that significant geographical variations exist. For the manpower element, it could be argued that the position of the NHS as sole employer of certain professions, and the national uniformity of pay scales, render such

differences marginal. But in those parts of the country where there is competition for administrative and ancillary staff it may be necessary to employ agency staff or offer posts on higher grades. Such circumstances are likely to occur in the London area, and RAWP recommended that, in addition to the London pay-weighting being reflected in target allocations, further compensation should be made subjectively when determining the rate at which actual allocations in the Thames RHAs would be adjusted. At the same time the Working Party recognised that published indices of wage rates and earnings were characterised by marked regional variations, and it recommended 'as a matter of some urgency that a detailed study should be undertaken to establish the scale and significance of geographic market cost differences and their effect on the provision of services at Regional and sub-Regional level'. Such research would require an analysis of the relative costs of providing defined standards of labour, in terms of factors such as age, skill and experience. The availability of such information on a national basis is a long way off.

Allowances for teaching

A small proportion of revenue is allocated separately to Regions to cover clinical facilities for medical and dental students at University Medical Schools (since 1974 undergraduate teaching hospitals have been managed by Health Authorities rather than funded directly by the DHSS). This allocation is independent of the calculation of the RAWP targets, but the Working Party made detailed recommendations regarding its determination. The Working Party's consideration of the higher-than-average costs incurred by teaching hospitals was confined to those costs directly related to teaching. It distinguished such costs from those incurred through the provision of highly specialised services (regional specialties) and through research - two activities which tend to be prominent in teaching hospitals. It was the omission of the latter which led RAWP to abandon the term Teaching and Research Allowance of its interim report, and adopt the name Service Increment for Teaching (SIFT). RAWP considered that finance for research and other non-teaching activities associated with centres of excellence should be found by Authorities from their main revenue allocations, and that Authorities should determine their own priorities for funding Regional specialties in relation to other services. It was argued that some allowances were made for Regional specialties through the adjustments made for cross-boundary patient flows - although such costs represent only average treatment costs and apply only to in-patients. It is interesting to note, however, that separate allocations were made outside RAWP for two London hospitals (Northwick Park and Hammersmith).

The SIFT allowance is determined by comparing the revenue expenditure of the teaching hospitals with that expected for new non-teaching hospitals. The resulting excess costs of the teaching hospitals are then expressed in relation to the number of students undergoing clinical teaching in each hospital. The excess costs, at March 1975 prices, ranged from £3,300 to £19,100 per student, and RAWP decided that the median excess cost should be taken as the starting point for SIFT.

Difficulties arose in attempting to differentiate between the various factors responsible for those excess costs. Hospitals lying close to the selected median were London teaching hospitals recognised as centres of excellence, and it was felt that the SIFT component should exclude any costs incurred by this excellence element. The Working Party relied on the study by the University of York (29) used in the Interim Report, in which it was assumed that 75 percent of the additional costs in teaching hospitals were attributable to the teaching element. Of the twenty teaching hospitals, fifteen (including all those in London) had excess costs greater than the SIFT allowance of 75 percent of the median excess cost per student. The shortfall was to be found from within the managing Authority's ordinary revenue budget. In a period of economic restraint, Authorities have found it impossible to maintain funding levels of teaching hospitals whilst at the same time developing services for the priority groups. Teaching hospitals and other specialist centres are largely concentrated in London, where it has been claimed that 'the whole service is being weakened in a random and unplanned manner' (26). Again, the difficulties arising from the separation of planning services and allocating resources are evident, as is the need to differentiate between issues for which priority decisions can be taken locally and those which have national significance. The balance between service provision, teaching and research is clearly within the latter category, and Lowe (30) has argued that funds incurred by the NHS in support of medical education should be identified and separately allocated and accounted for. Such an argument may well be extended to centres of excellence. If their continued existence cannot be maintained, then this should be reflected in an explicit policy decision. A squeeze on resources in those authorities where they exist, however, may only result in other services being reduced.

Movement towards targets

A Region's revenue allocation for the coming financial year is determined largely by comparing its target with its current allocation. RAWP recommended that changes should be in proportion to the distance between current allocations and targets, subject to certain limits. The limits recognise that a below-target Region may not be able to use large amounts of additional revenue effectively without an appropriate capital infra-structure or without a supply of appropriate manpower, and that above-target Regions may not be able to take a reduction in revenue without severe, unplanned, and inefficient cuts in services. Regional targets, and the rate of movement towards these targets, will be largely influenced by national growth rates. RAWP therefore considered it inappropriate to recommend absolute limits within which change might occur (floors and ceilings), but suggested certain guiding principles to be considered in relation to national growth rates. Notwithstanding the difficulties of forecasting growth rates, an analysis of the time required for Regions to achieve their targets would have been of considerable interest, but there is no evidence that this was done.

Implementation of the RAWP proposals:
Regional revenue allocations

Table 1 illustrates the effect which the implementation of the RAWP proposals has had on Regions' revenue allocations from 1978-79 to 1980-81. For the provincial Regions, allocations have moved consistently in the direction of targets; for the Thames Regions (all above-target) no consistent pattern is evident. Over the three years, the largest percentage change in allocation has been experienced by the North Western RHA, which in 1978-79 was the most below target Region. Its allocation has subsequently moved from 13.6 percent below target to 8.2 percent below target in 1980-81.

The most above-target Region, North West Thames RHA, has moved from being 12.8 percent above target in 1978-79 to 12.4 percent above target in 1980-81. The rate of movement has been somewhat erratic over the years, and overall is much slower than that envisaged when the RAWP Report was published. Factors which have slowed the pace of change include low national growth rates, the application of cash limits, and political pressures - notably from the Thames Regions. With minimum growth rates varying from 0.3 to 1.0 percent, no Region has actually experienced a cut in

Table 1

Percentage Differences Between Targets and Allocations for Regional Health Authorities

REGION	1978-79 start figure	1978-79 start plus addition	1979-80 start figure	1979-80 start plus addition	1980-81 start figure	1980-81 start plus addition
Trent	-12.6	-8.3	-12.0	-8.8	-8.2	-7.5
North Western	-13.3	-8.9	-10.4	-7.5	-8.2	-7.5
Northern	-12.5	-8.2	-10.2	-7.2	-6.8	-6.1
East Anglia	-8.8	-6.2	-8.5	-5.8	-6.6	-5.9
West Midlands	-9.6	-5.7	-7.6	-5.1	-5.5	-4.9
South Western	-6.4	-4.1	-6.4	-4.0	-5.0	-4.4
Wessex	-6.8	-3.8	-6.0	-3.7	-4.6	-4.1
Yorkshire	-6.1	-3.6	-6.0	-3.7	-4.1	-3.5
Mersey	-4.6	-2.4	-2.9	-1.0	-1.4	-0.9
Oxford	0.2	1.7	-1.2	1.6	-0.7	-0.3
S W Thames	4.9	5.9	4.6	5.9	4.9	5.2
N E Thames	12.0	12.5	9.0	10.0	9.7	10.0
S E Thames	10.1	10.7	10.5	11.5	10.3	10.6
N W Thames	12.8	13.3	12.1	13.0	12.4	12.7
Min Growth	+0.6%		+1%		+0.3%	
Max Growth	+4.0%		+3%		+0.6%	

For each year, the first column represents the percentage distance between the start figure (the previous year's allocation, updated for pay and price changes) and the target. The second column represents the percentage distance between the target and actual allocation, which includes the RAWP addition.

its allocation or a standstill. But whilst each Region's allocation represents a notional growth, the imposition of cash limits, which have failed to account adequately for inflation, has meant that cuts have been necessary.

Thus, whilst the RAWP principles were closely observed in the determination of targets, the real redistribution of resources has failed to materialise in the absence of significant national growth. This position might be contrasted with the Secretary of State's statement which accompanied the announcement of the Regional allocations for 1979-80:

> in a few years this Government will have made a real impact on a major social injustice ..... we are on course for the achievement of equity between Regions in the mid-80s. (31)

Growth rates from +1 to +3 percent were considered by the Secretary of State to be sufficient to enable 'the building up of much needed services for the elderly, the mentally ill and the mentally handicapped', although in practice the shift of resources to those care groups has been at a very much slower rate than that envisaged in Departmental guidance. The frustration experienced by the Government at such slow movements towards policy objectives had been manifest a year earlier when the Chancellor announced in the 1978 budget a special allocation for the NHS. Guidance along the lines of Priorities for Health and Personal Social Services and The Way Forward was given for specific areas of expenditure eg. day surgery, staffing in the mental illness, mental handicap and geriatric sectors, and health education. The accelerated commissioning of major capital schemes was also encouraged, although the Secretary of State accepted that 'bringing forward the date of commissioning may in some instances make necessary for the time being some further deviation from a steady process of redistributing resources to ensure fairer shares'. (32)

Despite voluminous comment on the inadequacies of RAWP, until 1980 the only significant change to the RAWP method was the introduction in 1978 of cost weightings for occupied bed days for different disease categories. Changes in the information base have also taken place as the data have been updated and expanded (eg. the SMRs are now calculated from four years' mortality data). In late 1978 a revised set of specialty cost estimates for cross-boundary flows was announced (33). A modified regression model was used to derive estimates with 'acceptable degrees of standard error' for each of 33 specialties. Rather strangely, these were then grouped into 15 categories 'because this is the maximum number for which the computer is currently programmed'!

In August 1980, the DHSS made available to the service the report (34) of the Advisory Group on Resource Allocation (AGRA). This group had begun work in late 1978 with the following terms of reference:

> to consider detailed improvements in the methodology recommended by RAWP as new data and the results of research studies become available, and to advise on any practicable and desirable changes which could improve the process of resource allocation...

The terms of reference were further constrained by the rider that it was outside the Group's remit to consider changes in the principles laid down by RAWP. This, together with an iteration of the RAWP view that only factors for which supporting data was readily available should be considered, rendered the Group's activity largely ineffective. Moreover, the pre-occupation with the determination of regional targets reduced its relevance below regional level. In the time available, the Group's considerations were confined to revenue, and before the release of its report the Group suffered the fate of other quangos. A plea for the establishment of a similar forum to coordinate further research and consider proposals for changes has been recently made from within the NHS (35).

Early in 1980, the Secretary of State gave preliminary consideration to some of the Group's recommendations and as a result certain modifications have been made to the formula to determine the 1980/81 allocations (36). The most important changes are:

a) an adjustment to reflect the effects of market forces on labour costs in the GLC area, in addition to London weightings;

b) the identification and costing of separate cross-boundary flows for 'multi-Regional clinical services' (eg spinal injury services) defined by the DHSS.

The Group's other recommendations involved relatively minor modifications, in the main relating to SIFT.

The RAWP Recommendations - capital allocations to Regions

There has been no formal mechanism for linking revenue and capital allocations, other than for new major capital developments by means of RCCS. The problems in changing the pace or direction of capital allocations are quite different from those for revenue. The time involved is longer and the discontinuation of capital projects may result in waste and inefficiency; on the other hand, the fulfilment of past commitments may result in delay in the process of redistribution.

As with revenue, the RAWP approach was to determine a population's need for resources, and then to apportion available resources in relation to such needs, resulting in target allocations. A comparison between current resource levels and targets forms the basis for settling actual allocations. RAWP judged that a population's relative need for capital was very similar to that for revenue, and the revenue formula was therefore used as a basis for determining target allocations, but with the following modifications:

a) population estimates were replaced by population projections for the fifth year following the year of allocation, to reflect the longer time-scale of capital investments. It was assumed that age/sex utilisation and mortality patterns were likely to remain stable over the five year period;

b) the FPC component was omitted, on the basis that capital expenditure on this category is minimal;

c) the cost-based age weightings for Community Health Services were replaced by GP consultation rates by age/sex derived from the General Household Survey. It was argued that the former weights were based largely on services which were provided from revenue funds. There was no indication, however, of the extent to which the latter weights offered an improvement;

d) cross-boundary flows were omitted, other than for agency and extra-territorial management arrangements. It was recognised that some cross-boundary flow arrangements would necessarily continue for a long time, for example with recognised centres of excellence, and it was recommended that suitable funding arrangements be made between RHAs outside the RAWP formula;

e) the adjustment for old long-stay psychiatric patients was omitted;

f) the six service populations were weighted by forecast national proportions of capital expenditure. Those forecasts were based on RHA estimates and capital projections as provided in the Consultative Document on priorities.

The definition of capital used in the NHS (37) suggested that it might be appropriate to use a revenue weighted population as a measure of the need for the smaller capital items (eg. equipment, vehicles). Further analysis indicated that the results would not differ significantly from those given by the method described above, and so that option was rejected.

Valuation of capital stock

An assessment of existing capital must take account of both quantity and quality. There was no recognised method for valuing capital, so it was necessary for RAWP to derive its own. A detailed survey was not practical, and therefore a method based largely on existing available information was sought. Levels of energy consumption and rateable values were considered and rejected, but no details of why they were rejected were published. The number of available beds was also considered as a measure of quantity, but this was rejected as it relates only to hospital in-patient services and neglects all supporting services, out-patient services, and community services.

The method finally chosen consists of two factors. The first is the level of capital expenditure since 1961 (this seems arbitrary but presumably relates to the 1962 Hospital Plan and the availability of suitable information). It relates principally to new buildings, though it also incorporates an element for replacement and upgrading. The second factor is an assessment of the capital stock built before 1961, which is calculated from the cost of

replacement at current prices. In practice, this exercise is confined to hospitals and health centre accommodation. Hospital stock is approximated by the number of beds. Replacement costs incorporate all supporting services (including out-patients), works fees, furniture and equipment etc., but exclude land. Two different costs are used relating to different types of bed. The cost of an acute bed is assumed to be equivalent to the capital costs of an acute bed in existing DGH schemes. The cost of a non-acute bed is based on cost allowances for a 150-bedded community hospital. The resulting capital cost of a non-acute bed is exactly half that of an acute bed.

In order to incorporate quality, the current replacement costs of 1961 stock are depreciated according to the age and the 'condition' (this was undefined) of the stock, and the post-1961 capital expenditure is depreciated according to the year of allocation. To depreciate stock levels of 1961 to reflect age it is necessary to have first, an assessment of stock volumes before 1961 and second, a set of depreciation factors. These two elements are then combined into a single weighted depreciation factor. Stock volume is approximated by hospital floor area from the 1972 Hospital Maintenance Survey. In a sample of hospitals in each Region, floor area was specified in each of three age bands: pre-1919, 1919-48, and 1949-72. For RAWP purposes, it was assumed that:

> a) floor area per bed is the same in the responding and non-responding hospitals
>
> b) the ratio of floor areas for the periods 1949-61 and 1962-72 is the same as the ratio of capital expenditure in the same years.

The derivation of depreciation factors to apply for each of the time periods is based on the assumption that different constructional components of a hospital (eg. walls, floors) depreciate at different rates. Depreciation factors relating to these components were derived, but neither their values nor their means of derivation were published. The factors were then applied to the relative proportions of DGH costs which correspond to the different components (again unspecified), and overall depreciation factors resulted for each time-period. The RAWP Report then, somewhat surprisingly, stated that:

> the effect on these overall results of varying the depreciation factors related to the various elements of hospital construction was tested but found to be insignificant

but there is no evidence presented to support this statement. For each Region, the depreciation rates for the three time periods were then weighted by the floor area proportions, resulting in a weighted average depreciation factor for each Region. These factors were then used to 'write down' the 1975 costs of the 1961 stock levels.

Capital expenditure post-1961 (at constant price levels) was depreciated at an annual rate based on the overall weighted depre-

ciation factor for the period 1949-61. The resulting estimate of the total stock value for each Region was further adjusted to account for hospital closures, downgradings and transfers since 1961.

For primary care services, the absence of comprehensive information and the wide range of premises meant that no valuation was possible other than for health centres. Those in existence at reorganisation in 1974 were costed at 1975 replacement costs at a figure which 'took account of other primary care services'.

Movement towards targets

The stock valuations for each Region are aggregated to provide a measure of the total capital wealth of the NHS. This sum is then notionally divided between Regions in proportion to the Regions' weighted populations reflecting the need for capital. The resulting sums represent the Regional targets, and these are compared with the existing stock values for each Region, to determine excesses and shortfalls. RAWP stated that the ultimate objective was to allocate all new capital on a weighted population basis, but that this was not possible whilst significant shortfalls existed in some Regions. The removal of such shortfalls should therefore be the immediate objective. But the pace at which this can take place will be severely constrained by the Regions' ability to absorb additional capital, by the relative inertia of the capital planning process, and by the need for capital to maintain existing stock, to fulfil contractual commitments already entered into, and to continue with existing plans based on earlier resource assumptions, unless such plans can be discontinued without waste.

RAWP therefore recommended that during a 'transitional phase' of ten years, while disparities in existing stock are removed, capital should be allocated on two bases:-

a) a 'set minimum' based on:

for 1977-78 and 1978-79 - 90 percent and 80 percent respectively of the planning assumptions already provided by the DHSS for those years;
for 1979-80 onwards - weighted populations applied to a certain proportion of available capital, the proportion increasing from 70 percent to 90 percent by 1986-87;

b) for Regions with capital shortfalls, the remainder should be allocated in proportion to those shortfalls, subject to a maximum. The maximum differs for each RHA and is related to its expected share if all capital were distributed on the basis of weighted population. The maximum is thus defined as a percentage of the population-based share, and rises from 110 percent in 1977-78 to 140 percent in 1980-81 and thereafter.

In order to avoid large variations in allocations from one year to the next, RAWP recommended that annual changes be limited to 20 percent.

Other Capital Allocations

Several capital allocations are made to Regions outside the RAWP process. Some allocations relate to specific schemes (e.g. additional costs of teaching hospital schemes); some relate to specific policies (e.g. the building of secure psychiatric units); some concern more general policies (e.g. energy saving); and some relate to policies outside the NHS which have a bearing on health care (e.g. joint finance, aids to the construction industry). The rationale for such allocations contrasts with the RAWP philosophy. They are intended for specific purposes and are allocated with the minimum of notice in an unpredictable manner, militating against the concept of smooth changes in allocations. Unless capital plans have reached a state of development in which they can be implemented at short notice, then such allocations will be used inefficiently (in practice, a high proportion of the money is usually 'carried over' into the next financial year because it cannot be spent). This is another illustration of the gap between resource allocation and service planning.

Implementation of the RAWP Proposals- Regional Capital Allocations

For the first two years of operation of RAWP (1977-78 and 1978-79), 'set minima' were calculated for each Region as a percentage of the planning assumptions. The percentages differed from those advocated in the Report, and adjustments were made where it was considered that the basic allocation was insufficient to meet commitments from existing capital contracts. The balance of available capital was distrtibuted 'broadly in accordance with the principles set out by RAWP' (38).

For 1979-80 and 1980-81 allocations were determined as recommended by RAWP, except that the 'set minimum' component was based on 85 percent of available capital, rather than 70 percent as recommended. Thus whilst, as reported by the Secretary of State (31), 'the 1979-80 capital allocations for the first time make a modest move towards equalising Regional capital stock', such movement was much less than first envisaged, only 15 percent instead of 30 percent of available capital being directly available for distribution to RHAs falling short of their targets. The reason given for this was 'to mitigate the impact of the changes of regional allocations' (39,40), and a limit of 10 percent (rather than 20 percent as recommended by RAWP) was applied to any Regional changes.

8. Resource allocation within the NHS Regions — the practice

It was RAWP's intention that the method adopted for determining Regional targets should be applied 'as nearly as possible in the sub-Regional context' and that targets for Areas should comprise an aggregate of the targets of the constituent Districts. In this chapter we review the methods adopted for allocating finance within Regions. A comparison is made of the different interpretations and modifications of the RAWP proposals, and significant variations in approach are highlighted. The relationship between resource allocation and planning is discussed, and the problems of reconciling these processes within Regions are examined.

Sub-Regional Revenue Allocation

Criticism of the Resource Allocation Working Party's recommendations for allocating resources sub-Regionally has been of two broad types - the first relating to the use of a formula-based method, and the second relating to the structure of the RAWP formula and its supporting information base. RAWP itself voiced several reservations about the use of its formula sub-Regionally, though these were understated and the analysis of the likely implications was too crude.

The first type of criticism centres on the inadequate reference to the way the NHS works. The organisational complexity and variations in local circumstances are such that a mathematical formula provides an insensitive means of resource allocation. The value of subjective assessments of local characteristics and requirements is argued forcibly by Cuninghame-Green, who criticises RAWP's 'failure to distinguish between the province of formulae and the province of judgement' (1). In particular he was concerned that RAWP's approach would remove much responsibility from local management and would result in 'a negation of the role of professional judgement'. It has also been suggested that local management decisions might be taken with a specific awareness of the effect on the formula and hence on subsequent allocations (2). The recognition that RAWP gave to local circumstances was related not to the determination of the targets themselves, but only to the pace of change towards targets. It emphasised the need to consider local priorities and plans, and stated that 'differences will continue to exist between localities ..... as a result of planning decisions taken within the framework of compatible allocation mechanisms'. No further indication was given of how such compatibility might be attained.

The second type of criticism relates to the magnitude at sub-Regional level of some of the variables in the formula, and the consequent effect on targets. Whilst the need to take account of 'differences in scale' was recognised by RAWP, the advice on this was unclear. Despite statements such as 'fewer age/sex bands would have to be used' and 'condition-specific SMRs can be used with some loss of reliability due to the smaller numbers involved', it was then stated that sensitivity tests showed that 'insignificant changes' would arise and that in the case of SMRs 'the results would still be closer in most cases to the notionally correct result'. It is the sensivity of the RAWP formula to changes in data at sub-Regional level which is critical. An analysis of this sensitivity has been conducted in the West Midlands Region (3). By studying the effect on Area targets of changes in data values, the most significant factors within the formula were identified, and the effect of possible modifications to the formula itself was assessed.

A wide variety of approaches have been adopted by Regions in the determination of sub-Regional resource allocations. In some Regions the RAWP recommendations have been adopted fairly rigidly, whereas in others substantial modifications have been made. The interpretation of the resulting targets has varied from broad indicators of direction to mechanistic objectives. The proportions of Regional development monies allocated on a RAWP basis have also varied, and have been dependent on different policies regarding the maintenance of special financial reserves (such as for the revenue consequences of new capital schemes). Views within Regions have tended to polarise between the potential gainers and the potential losers, but the majority have welcomed the attempt to provide an objective framework for resource allocation. A detailed description of the implementation of RAWP in each Region would be lengthy and repetitive. Instead, each factor in the formula will be considered in turn and where significant variations in approach exist between Regions, the main differences will be highlighted.

Service Populations

Whilst it was not RAWP's intention that individual service populations should be used as a guide to determining allocations to those services, it is intuitively desirable to have some means of reconciling the population components used for resource allocation with the populations used to plan services. In this respect the RAWP service populations are not easily reconciled with the client groups defined in DHSS planning guidance. Nor is it easy to link RAWP with programme budgets. Although several Regions comment along these lines none of them attempts to depart significantly from the RAWP framework; but some omissions and additions do arise. The ambulance and FPC components are sometimes left out (they were both excluded by SHARE). For mental illness and mental handicap, the RAWP approach is considered by some Regions to be quite inappropriate to the local situation and these service populations are omitted completely, allocations being determined by a separate process. One Region has incorporated acute mental illness in the non-psychiatric in-patient (NPIP)

component. In another Region (and in SHARE) it was considered that the NPIP component should be broken down to enable the separation of maternity services.

Weighting factors applied to service populations

Most Regions have recognised the inadequacy of using historic national expenditure proportions, and some have used their own more recent expenditure data. The sensitivity analysis undertaken in the West Midlands Region showed that this modification produced a significant change in Area targets (1.5 percent on average), but less significant change resulted when expenditure proportions based on policy guidance were used (such as a reduction in acute services, or an increase in psychiatric and community services). The suggestion of linking service population weightings to policy guidance was made by several Regions but none implemented it. One Region suggested that, in order to be consistent with the Region's target, expenditure proportions applied sub-Regionally should equate with the Regional service populations as a percentage of the Regional target, but again no Region took this suggestion up.

Population base

All Regions have commented on the unreliability of population estimates, especially sub-Regionally. Many Areas have argued that Local Authority estimates are better, with local knowledge of migration and housing developments, but to ensure consistency Regions have adopted OPCS figures. One Region used projections to the year of allocation instead of estimates. Another Region used estimates for the year prior to the year of allocation. It will only be possible to assess after the 1981 census how inaccurate the estimates have been, but the sensitivity of the formula to changes in population figures is worth noting, and close scrutiny of other factors may be of relatively limited value.

Cross-boundary flows;
Non-psychiatric in-patient services

At sub-Regional level cross-boundary flows can be very large, particularly in urban areas, and they can have a significant influence on target allocations. Some Regions have chosen to use District catchment populations as a base, rather than the resident population with a separate cross-boundary flow adjustment. It might be argued that it is most appropriate to use different catchment populations for different ICD groups, for it would then be possible to use directly the cost-weighted age/sex bed utilisation rates and SMRs which are both classified by ICD group. This approach obviates the inconsistency of aggregating a resident population with weightings based on ICD classifications, and a cross-boundary flow adjustment with weightings based on specialties. One difficulty with catchment populations is the determination of their age/sex structure. One approach would be to assume

that the structure of the 'transferred' population is either the same as the District of treatment or the same as the District of residence. Alternatively, the age/sex structure of the patient flows themselves might be considered. A similar problem arises with the determination of SMR weightings for catchment populations. One Region has used planning (catchment) populations based not on actual or projected cross-boundary flows, but on geographical access measured by travelling time. Though this approach is consistent with the RAWP objective of 'equal opportunity of access', there are two important problems. The first is the technical problem of determining the age/sex structure and SMRs for these populations, and the way this is solved is not clear. The second is the behavioural problem of whether GPs would modify their referral patterns in accordance with such a criterion. Nevertheless, this approach is a real attempt to bring planning and resource allocation together:

> The retrospective RAWP method perpetuates those very deficiencies it was designed to remedy. The gap between planning and RAWP can be bridged by making planned catchment populations the basis of revenue targets. (4)

Cross-boundary flow data from HAA is usually at least two years out-of-date. Some Regions have attempted to update it. One Region sent a questionnaire to Areas asking for an assessment of the effect on patient flows of capital developments commissioned between the year of the most recent HAA data and the year of allocation. This approach involves the difficulty of reconciling conflicting assessments between Areas. Some criticisms were voiced that HAA is incomplete. In the sensitivity analysis undertaken in the West Midlands Region, cross-boundary flows were proportionally increased to assess the effect of possible incompleteness on Area targets. For large importing or exporting Areas the effect is significant (up to a 2 percent modification to the calculated target), but no Region has implemented any adjustment for incomplete data on patient flows.

Most Regions have used the national specialty cost estimates recommended by RAWP to weight the cross-boundary flows, other than for regional specialties. Several Regions have questioned the use of average costs on the grounds that a large proportion of cross-boundary flow cases probably incur above-average costs. Some Regions have commissioned studies to test this hypothesis, but the difficulties of determining costs for individual patients or small groups of patients has resulted in the use of proxy measures (such as number of tests, number of operations, length of stay), and the results have proven inconclusive (5). The sensitivity analysis illustrated that increasing all specialty costs by 25 percent would result in variations ranging from -8 to +3 percent in Area targets in the West Midlands Region. In some Regions, costs have been estimated for different groups of specialties from those used by RAWP using an alternative regression model for which it is reported (6) that the resulting estimates of cost per available bed (rather than cost per case) are more accurate. It is not evident, however, that these alternative estimates have been used in determining sub-Regional targets. One Region has enhanced the

cross-boundary flow adjustment by having a cross-boundary flow component outside the formula and hence not subjected to any scaling when incorporated with the weighted resident population. In some Regions, the cross-boundary flows have been expressed not in population equivalents, but in terms of cash, the aggregate of which has been distributed outside the RAWP process.

Certain anomalies arising with the use of net cross-boundary flows have been pointed out (7). Each District has its own admission rate, but the cross-boundary flow is translated into population equivalents using the national admission rate. In the case where the local admission rate exceeds the national rate, then more than the total District resident population is apportioned. If the local admission rate is less than the national rate, then less than the total District resident population is apportioned. A suggested improvement is to consider the cross-boundary flow in each direction separately, to convert to population flows, and then to take the net aggregate of these flows.

There is a wide variation between Regions in the approach to the funding of regional specialties (and even in the definition of what constitutes a regional specialty - see chapter 6). Most Regions have excluded these specialties from the cross-boundary flow adjustment and have funded them outside RAWP. Where the regional specialties have been provided in single-specialty hospitals, the determination of allocations has been relatively simple. In multi-specialty hospitals, however, the need for better cost information has been highlighted.

Cross-boundary flows: Out-patient and day-patient services

All Regions point to the lack of information about cross-boundary flows of out-patients. The approaches adopted vary widely. Some Regions make no allowance for cross-boundary flows; some assume that flow patterns are reflected (totally or partially) by those of in-patients; some Regions have conducted special surveys (8). One Region has made an estimate of out-patient cross-boundary flows by comparing, for each Area and each specialty, the actual number of out-patient cases with the expected number. The latter was derived by using national out-patient attendance rates by specialty, assuming the same distribution over age/sex groups as for in-patients in the same specialty. It was assumed that the difference between actual and expected cases was a result of cross-boundary flows, and no allowance was made for possible differences between local and national access rates.

Standardised Mortality Ratios

SMRs have been the subject of much debate and research by Regions, and substantial variations in application have resulted. On the one hand, some Regions have used SMR weightings in the form recommended by RAWP; on the other, some Regions have excluded SMR weightings completely. The sensitivity analysis indicated that the effect of these two extremes of approach on Area targets in the West Midlands Region was an average change of 2.7 percent (ranging

from -4 to +6 percent) in the calculated targets. In between these extremes, some Regions have attenuated the effect of SMRs by adopting the average of an SMR weighted population and a non-SMR weighted population, or by modifying the SMRs themselves. In recognition of the sensitivity of disease-specific SMRs at District level to chance fluctuations in the level of local mortality (9), three Regions have undertaken detailed studies and two have concluded that, at least until a larger mortality data base is generated, SMRs should be recalculated with certain disease groups aggregated. The ICD chapter groups selected for aggregation by the two Regions were not identical and different criteria have been used for their selection. In one Region, the need for aggregation was determined by the absolute number of expected deaths in any one year in any Health District. For the other Region, a combination of a threshold of actual deaths in any one year in the whole Region, together with tests of statistical significance, was applied. The third Region, however, concluded that:

> although part amalgamation of disease categories will very often produce a more accurate result, the improvement is likely to be slight and this procedure is, therefore, not considered worthwhile.(10)

Other Regions have tackled the problem by using, in the NPIP component, SMRs for all conditions together instead of individual ICD chapter groups.

Most Regions have used SMRs standardised by national mortality rates, but some have considered it more appropriate to standardise by their own Regional mortality rates. Some Regions have decided not to apply SMR weightings to all of the service populations to which weightings were applied nationally - for example, in some cases it was deemed inappropriate that the need for ambulance services should vary in proportion to a mortality index. There is no published evidence of any Region testing the appropriateness of alternative mortality indices.

Mental Handicap and Mental Illness

The methods adopted by most Regions varied widely from those used to determine Regional targets. Some Regions felt that the RAWP approach for these services was totally inappropriate sub-Regionally. The classification of patients into short-stay and long-stay, and the use of cost weightings for each, was judged to be arbitrary and inadequate. With short-stay cases, a problem arose with repeated admissions at frequent intervals, and some Regions chose to consider only the first admission for the purpose of assessing cross-boundary flows. For long-stay patients, it was not possible routinely to assess the actual numbers in hospitals according to the RAWP definition. It was also considered that inadequate allowance was made in the appropriate population components for psychiatric hospital day care and community care. On the basis of these and other arguments, some Regions decided that mental handicap and mental illness services should be a first

charge on available revenue, thus dealt with outside the RAWP process.

Most Regions have made some allowance for old long-stay patients, but several have departed from the RAWP definition. In some cases, surveys have been mounted to assess the number of old long-stay patients. Unit costs were promulgated by the DHSS with no reference to the assumptions behind their derivation. Several Regions have chosen to adopt their own costs. In some cases average Regional costs have been used and in others different costs have been identified within the Region (for example, average costs for each of the different Areas of treatment). There is no routine method for differentiating between the costs of short- and long-stay patients. For mental illness, one Region has adopted average costs in large hospitals for long-stay cases, and average costs in hospitals with short-stay units for short-stay cases.

Before 1978, strict adherence to the RAWP formula at sub-Regional level sometimes led to negative target populations for Areas with no psychiatric facilities. A common correction was for negative targets to be zeroed with a corresponding pro-rata reduction in positive targets. Negative populations, whilst theoretically possible, seemed intuitively wrong; they reinforced doubts about the ability of the data base to support the RAWP method, and caused one Region to abandon this approach for mental handicap and to base its targets on weighted catchment populations. Another Region has also preferred to use catchment populations for mental illness based on service planning agreements rather than historic cross-boundary flow data. This illustrates a leaning towards a catchment population approach for mental illness and mental handicap services where the catchment area boundaries can be clearly defined geographically; in such instances, resource allocation and strategic planning might coincide.

Other factors

In all cases, the SIFT allowance has been a first charge on the Regions' available revenue and has been allocated directly to the Teaching Authorities. In addition, one Region gave its Teaching Area a 'centre of excellence' allowance, based on the proportion 'directly attributable to patient care' of an updated 'residual excess costs' figure (given in the RAWP report) for that Region.

It is doubtful whether variatons in market costs within Regions are as significant as variations between Regions, and most Regions have ignored the issue. Three of the Thames Regions have, however, examined sub-Regional variations in market costs with varying conclusions. A joint working group (12) has attempted to derive a consistent approach, looking at variations in selected non-qualified staff costs between three labour markets - inner London, outer London and the non-metropolitan counties. A study of market-cost variations has also been undertaken in one of the provincial Regions (11). Whilst significant variations in expenditure were identified, difficulty was encountered in differentiating between labour market pressures and variations in staffing policies and available funds. The attempt to adjust RAWP targets was abandoned.

In discussing indicators of morbidity, several Regions refer to the possibility of making some allowance in Area targets for 'social deprivation'. Three arguments are commonly cited against this. First, the relationships between social factors and the need for health care are complex and not readily quantifiable. Second, socio-economic indicators are measured on a wide coverage only infrequently (at the decennial census). Third, the consequence might be to provide additional health care as a substitute for more appropriate welfare services. The latter argument was also used in rejecting the idea that Area targets should reflect the level of social services provision and other non-NHS services. However, a study within the Thames Regions (12) of the relationship between overall SMRs and 'social deprivation indicators' derived from the 1971 census highlighted 'wide and unacceptable discrepancies' which 'confirmed the necessity to take account of social deprivation independently of SMRs'. The outcome was a crude aggregation of three selected indicators and the application of (seemingly arbitrary) weighting factors to four of the service populations for each Area.

Expression and interpretation of sub-Regional targets

In most cases Area targets have been expressed as absolute values in both population terms and cash terms. Only rarely has an attempt been made to reflect uncertainty and generate a target range. When a range has been provided, it has been in relation to target assumptions rather than target allocations. Area targets have, without exception, been expressed as a proportion of the corresponding Regional target, and not the Regional allocation.

The way Area targets have been used to determine Area allocations is peculiar to each Region. The first consideration has been the portion of the Regional allocation held for RHA headquarters administration, Regionally-managed services, SIFT, and for Regional reserves (revenue consequences of medical appointments, revenue consequences of capital schemes, contingency reserves, and Regional specialties). The policies on these issues and the associated levels of funding vary substantially between Regions, and influence the extent of any resource redistribution within Regions. An amount equivalent to the previous year's Area allocations (adjusted for inflation) is also deducted from the Regional allocation. The remainder is then considered to be the 'development addition' which is distributed to Areas. Minimum and maximum growth rates are set depending on the Region's growth rate. Between these limits Areas are generally allocated additions in proportion to the distance between their allocation and their target, although in one Region, Areas have been 'banded' together and a growth rate specified for each band.

Reconciling Planning and Resource Allocation

Resource allocation is a complex process, and both the practicality and validity of a purely mechanistic method must be questioned. Such an approach would only seem appropriate when the

objective can be expressed explicitly in quantifiable terms. But 'need', 'risk' and 'opportunity of access' are vague concepts not readily amenable to measurement, and there is no reason to suppose that any formula will satisfy an objective couched in such terms. It cannot be assumed that financial allocations, however determined, will impact in a known regular manner on health needs. The relationship between financial allocations and physical resource levels may vary geographically. The relationship between physical resources and service levels may also vary according to local management policies. The relationship between service levels and health is indeterminate. It is more appropriate to use a formula approach simply as a signpost - a broad indicator of relative resource needs. This would then leave greater scope for influencing resource allocations at the local level with a more realistic assessment of relevant local circumstances. If the Government's policy to devolve decision making is to become a reality, the power to take decisions will have to be matched with the ability to allocate resources accordingly.

The concept of geographical equity has become a prime objective of resource allocation. Such a philosophy might be feasible in a time of growth in real resources when redistribution can be effected by applying different growth rates to different Regions. But substantial problems arise in times of economic restraint, when allocations are reduced, or when increases are so small that they are insufficient to allow for demographic changes, or when inflation is greater than that allowed for in cash limits. Unless there are obvious areas of waste and inefficiency, cuts in services are difficult to accept politically and morally. Resource redeployment is a much more complex process than might be inferred from the frequency with which it is suggested in national policy statements and planning guidance.

Given a formula approach, it is debatable whether equalisation is best achieved through capital or revenue allocations, or some balance between the two. The sharp distinction between capital and revenue tends to militate against taking effective decisions. A total pool of finance would facilitate the choice of a balance more appropriate to local requirements. Geographical inequalities could be met by a combination of capital (to provide a new service) and revenue (to run it), and both allocations should be derived on a common basis. In practice, the momentum of an inherited capital programme has meant that changes in capital allocations can only take place over a long timescale, and hence there has been greater emphasis on revenue equalisation. But the ability of authorities to absorb usefully additional revenue is contingent on two factors: a supply of appropriate manpower, and a suitable level of capital provision. Conversely, problems have been encountered with new capital schemes generating substantial requirements for revenue. Different policies have been adopted by different Regions; where RCCS is being phased out, either the intended rate of decline has been reduced or special reserves have been established. With some below-target Areas, RAWP additions have been used as a direct substitute for RCCS; with some above-target Areas, it has been impossible to find revenue by cuts or redeployment and the commissioning of schemes has been delayed. The cancellation and delay of capital schemes is wasteful - large quan-

tities of resources are often committed at a relatively early stage in terms of land acquisition and design fees. A better strategy might therefore be to honour existing capital commitments together with associated revenue, at the expense of the shorter term geographical equalisation of revenue. In the longer term equalisation could then be achieved through planned service developments in conjunction with appropriate capital redistribution.

The limits on the transfer between capital and revenue (currently 1 percent of revenue can be transferred to capital and 10 percent of capital to revenue) are restrictive and not conducive to imaginative planning - the necessary balance between the two resources will inevitably be different in different plans. This constraint was partially acknowledged in the notification by the DHSS (13) of a willingness to relax the limit of transfer from capital to revenue for those Regions which could provide adequate argument.

The use of cash limits has resulted in a reluctance to commit development monies during the first half of the financial year. Contingency reserves have been maintained to counteract the possibility of inflation higher than that allowed for in the cash limit. In the event that such inflation does not materialise, the limits on the carry-forward of under-spendings (currently 1 percent for revenue and 10 percent for capital) are likely to result in profligacy at the end of the financial year. Moreover, these limits on revenue prevent the 'banking' of funds for new services planned for later years, and result instead in inefficient spending on 'non-recurrent' revenue items. The difficulties in meeting pay and price rises agreed outside the authorities' control (pay awards, increase in value-added tax) have been severe, and this led to the notification (14) that from 1979 Regional cash limits would be adjusted to reflect the 'excess cost' of pay settlements. Nevertheless, the use of development monies for contingency reserves has meant that the slow redistribution of financial resources has resulted in an even slower redistribution of services. The redistributive effect of RAWP has also been constrained by the use of revenue for the maintenance of capital stock. Several Areas have found it necessary to deploy development money on building maintenance, yet no assessment of stock quality has been allowed for in the determination of their revenue allocations.

It is sometimes argued that the achievement of the RAWP objectives is slowed down because actual allocations are determined at short notice. In addition, it is argued that more efficient spending patterns could be achieved if a more accurate forecast of future allocations could be provided. The difficulties of predicting changes in the national economy and in political factors, which influence the health service vote, are evident; there can be no resource allocation mechanism within the NHS which is not sensitive to such realities. The advantage of an objective formula is that it can provide a consistent basis for forecasting change. If health authorities were provided with a range of resource forecasts resulting from different sets of assumptions, then these could be used as a basis for constructing alternative planning scenarios. The need to consider alternative plans is no less

important in the NHS than in other organisations, where equivalent levels of uncertainty arise in terms of supply, demand, and production. Yet the NHS seems reluctant to contemplate the problem of uncertainty in planning and little use is made of appropriate analytical techniques (financial modelling, operational research) for the investigation of alternative options.

The structure of the formulae currently used for the determination of Regional and sub-Regional capital and revenue target allocations is very much influenced by the availability of information. The lack of appropriate data has led to the exclusion of any factor reflecting differential needs or demands for health care by populations of different social structures (other than age and sex). It has also led to the use of a mortality index as a proxy for morbidity. Within the structure of the formulae there are further obvious deficencies. For example, no information is routinely recorded on flows of patients across health authority boundaries for out-patient or day-patient care. Nor is there any register of capital assets, with details such as age and replacement costs. Indeed, one of the characteristics of the existing accounting system is that it does not encompass capital. The inability routinely to amortize capital assets and plan for their replacement provides a substantial obstacle to effective planning. Other deficencies in the availability and accuracy of cost information are evident. None of the required cost data (specialty costs, ICD group costs) are readily obtainable from the existing costing system. They are all derived by crude processes of approximation and apportionment.

The need for better information, not only for resource allocation but also for planning and monitoring, was stated at reorganisation in 1974, and on several occasions since. During 1978, discussions took place between the DHSS and NHS with a view to identifying the main problems and establishing priorities for action. The results outlined in a consultative document (15) pointed to the need for a comprehensive review of information systems, but judged that the resources required for such a task rendered it impracticable. Instead, coordinating machinery has been established in the form of a joint NHS/DHSS steering group to guide developments in health information, and to assign priorities to individual proposals for action. This opportunity to improve the information base for resource allocation and planning should not be missed. It would be disappointing if this exercise was used as a smokescreen while the volume of routine statistical returns and the resources invested in information systems were reduced.

Under the general guidance of the steering group, the DHSS has also initiated a joint review of costing and financial accounting in the NHS, largely in response to criticisms of financial information systems voiced in a study conducted for the Royal Commission (16). The main review body has established two working groups. One is concerned with reducing the quantity of routine data sent to the DHSS and has already reported. The other is concerned with wider requirements for financial information and is expected to report in 1981. It is currently considering evidence from various DHSS-sponsored studies. One of these has made firm proposals for a three-year programme of research to develop more detailed and precise cost information, to test the feasibility and

cost of obtaining such information, and to assess its usefulness in management, planning and resource allocation (17). The proposed approach entails the recording of resource consumption at a variety of different organisational and operational levels, some below that of the clinical specialty. Its feasibility depends largely on the ability to extract information from data collected for other operational purposes, which may be facilitated by recent developments in computer technology. A greater modification of existing patient information systems than of accounting systems would probably be required, and the opportunity should be taken to test the possibility of linking with other data relating to non-clinical patient characteristics (other than age and sex). The resulting information should provide more precise cost weightings for specialties, ICD groups, and age groups. These proposals could, therefore, be of importance to resource allocation in the NHS; but similar suggestions (18) made at the beginning of the decade have been totally ignored.

The validity of data bases is more critical at sub-Regional level than at Regional level. Large fluctuations in data values can arise by chance, and the sensitivity of the various formulae to such changes should be investigated in more depth. An assessment of the relative significance of different items would be a guide in determining priorities for information studies such as those described above. There is no evidence that such investigations were performed on a national basis by RAWP. Some proposals were made for further research which resulted in the establishment of the Advisory Group on Resource Allocation, but its terms of reference were confined to superficial aspects of the existing formulae. There is clearly a need for further research of a more fundamental nature.

Whilst the diversity of the methods for determining sub-Regional allocations may coincide with a policy to devolve decision making, it is clearly incompatible with the basic RAWP objective of geographical equity. The situation arises where allocations for neighbouring Areas are based on different criteria only because they are located in different Regions. Moreover, their allocations could differ substantially if (all other things being equal) one is in a RAWP-gaining Region and the other is in a RAWP-losing Region. Recognition of the different methods employed by the Thames Regions despite their collective responsibility for providing services in Greater London led to the establishment at the end of 1978 of a joint DHSS/RHAs working party, with the objective of deriving a common approach.

At present the determination of resource allocations to Regions, and from Regions to Areas and Districts, is quite separate from the formulation of plans. Resources are allocated from a given tier to the one below, and plans are submitted in the opposite direction, but the influence which plans have on allocations is small. Resource allocations and planning guidance are based on the separate criteria of geographical equity and client group policies respectively. In a report to the Standing Group on Planning (19), it was stated that 'any integration would be a complex operation which would not be embarked upon at the present time'. Nor is reconciliation aided by RAWP's explicit statement that any consideration of the use of resources, once allocated, was outside its

remit. There are, however, opportunities within the formula for linking resource targets and health care policy. This linkage could be effected by changes in data, such as cross-boundary flows or service expenditure proportions, which reflect planning guidance or forecast the effect of existing plans. Most Regions have used historical data which reflect previous health care policies and patterns of supply and demand. One Region, however, states that it is looking to its strategic plan as a basis for revenue funding and suggests that 'this alternative to RAWP be kept very much under review' (20). Another Region is in the process of piloting an 'Integrated Planning and Resource Allocation System' (21) in which a proportion of available Regional revenue is allocated to Areas by RAWP methods, and the remainder is allocated in response to Area plans. One commentator (22) advocates that this policy be taken even further, resulting in a complete 'bottom-up' approach:

> Resource allocation should begin, not at the apex of the hierarchy as the problem of dividing a homogeneous resource called money .... but at the base of the hierarchy as a management problem of estimating what needs to be done, of formulating projects, costing them and attaching some index of priority.

But there would still be a need to determine which plans should be implemented and to allocate resources accordingly.

The difficulties in reconciling formula-based resource allocations with plans is well illustrated by the dilemma faced by one Region in respect of the development and funding of its in-patient services for the mentally handicapped. Whilst target allocations were viewed as totals instead of considering each component as indicative of the expenditure to be allocated to particular services, the mental handicap component for individual Areas was examined for illustrative purposes. The method of calculating this component (from a weighted resident population adjusted to reflect short-stay cases and long-stay cases) results in those Areas with no mental handicap in-patient facilities being accorded substantial positive mental handicap service components, in aggregate amounting to 26 percent of the total mental handicap component for the Region. It might be argued that this is indicative of either poor quality data giving rise to inadequate adjustments to reflect existing service patterns, or of the amount of 'need' for mental handicap in-patient services generated by such Areas which is not currently met by services provided in other Areas and for which in-patient services should be developed. In any event, these Areas do not plan to spend any money on developing in-patient services for the mentally handicapped. (Several do, however, plan to develop community services, and consideration of the weighting accorded to the community health services component shows that almost no expenditure on mental handicap community services is incorporated, because little exists). Those Areas which do, and will continue to, provide mental handicap in-patient services appear to be receiving inadequate recognition. A Regional strategy for the development of mental handicap in-patient services has been defined in terms of catchment area boundaries. The question now under

consideration is whether to fund such services outside RAWP (as some Regions have done), to use the RAWP approach but base the Area mental handicap components on weighted catchment populations, or to use the RAWP method without modification.

Setting Budgets

The need to reconcile health care policy and resource allocation is important at the operational level, since the implementation of any policy is ultimately effected by allocations to budget holders. Even if resource allocations were consistent with plans and planning guidance down to the District level, it would still be necessary to have a mechanism to determine budgets according to plans within the District. The present budgetary structure is largely based on functional responsibility (such as nursing, pathology, X-ray), and may not be directly compatible with the structure of plans.

The processes for allocating finance and monitoring expenditure at sub-District level (budget setting and control) are not systematic, and are not well documented. Officers with ultimate responsibility for controlling expenditure are often not involved in taking planning decisions. In principle, budget holders need to be informed about planned service levels and associated expenditure forecasts. The monitoring of plans should involve the return of similar information on achieved service levels and actual expenditure. In practice, monitoring usually involves only the comparison of actual expenditure against budget, with little regard to whether the pattern of work is in accordance with original intentions. Only when there is a large variation between budget and out-turn is there detailed scrutiny of the way in which expenditure is incurred.

All health service expenditure relates directly to inputs (resources provided). The translation of plans into budgets therefore requires the expression of planned objectives in terms of resources (beds, staff). Whilst the majority of plans are expressed in this way, others are expressed in terms of proxy outputs, such as population served, cases, or attendances. In some instances these measures are translated into resource levels within the plan; in other instances such translation forms part of the budget-setting process when the plan is being implemented. This requires the use of unit cost data relating to these proxy outputs. Existing cost data, however, provide little more than crude averages at a high level of aggregation.

The use of average costs may be paticularly inappropriate for plans involving marginal changes. The determination of marginal costs presents substantial problems. A simple marginal cost for a given service does not exist - it is dependent on a variety of local circumstances such as the level of throughput and spare capacity, which determine those costs which may be viewed as fixed and those which are variable. The distinction between fixed and variable costs will also depend on the timescale of the plan. For plans which relate to new capital developments, the costing information is crude. To determine revenue costs, authorities are supplied by the DHSS with average cost estimates derived from a

national sample of hospitals. The costing procedure purports to estimate expenditure by specialty and function, but the unit cost estimates are only averages across a range of specialties, with no recognition of case-mix.

The traditional approach to the setting of functional budgets has been to maintain the previous year's allocation and to make an appropriate adjustment for inflation. Economic constraints have recently led to the emergence of the zero-based approach, involving an appraisal of estimated workload and corresponding unit costs. Problems have been encountered not only in determining unit costs, but also in defining workload measures. The Financial Information Project (17) has suggested that the formulation of workload measures is more difficult than the allocation or apportionment of costs to such units. This may explain why nearly all Districts implementing the Standard Accounting System designated cost centres at the functional level, and the system consequently failed to produce financial information of relevance to health service planning.

Some plans are expressed in terms of outcome target levels (such as reduced incidence of disease), but the formulation of specific programmes to achieve such objectives requires the delineation of a complex structure relating resource levels to outcome measures. This exercise is rarely possible, and the links between expenditure and outcome remain largely unspecified. As Williams (23) has pointed out:

> it is broadly the case that budgets relate to organisations, but plans relate to activities ..... the general non-coincidence of organisations and activities will prove to be a major source of difficulty.

The greatest problems arise when plans relate to activities which involve both NHS and non-NHS services. Even within the NHS itself there are obvious difficulties with plans relating to more than one sector (hospital, community, family practitioner services), since these services are organised and administered separately and have independent information and budgeting systems. The programme budget approach adopted by the DHSS is one example of an attempt to formulate plans and identify expenditure for population subgroups, cutting across organisational and functional boundaries. Whilst such an approach might be satisfactory at the national level to provide a 'broad brush' appraisal, substantial difficulties arise in adopting this approach at District level, even at the preliminary stage of identifying existing expenditure by client groups (24). Attempts to express District budgets in client group terms have thus far been of little value. Even if such budgets can be defined, plans for client groups still have to be translated into functional expenditure patterns for practical purposes. This is a difficult exercise, although research in Scotland (25) has demonstrated a move in this direction for maternity services.

The implementation of a client group budgeting approach would require individuals or teams to act as secondary budget holders for each client group. One possibility might be the designation of District Planning Teams as collective budget holders; the absence

of budgets for client groups, and the consequent lack of influence over the way resources are spent, has reduced the effectiveness of DPTs to date. The wide range of resources used by individual client groups would necessitate a primary level of budgets, which might correspond with the existing functional structure. Many functions will provide a service for more than one client group, and some process of apportionment would therefore be necessary between primary budgets and secondary budgets. The lack of information on patterns of resource use by client groups would render much of the apportionment arbitrary, and until a better information base is available it is doubtful whether such a two-tier approach will receive serious consideration.

Historically, the definition of budgets has been related to local management structures and defined responsibilities. But difficulty in expenditure control arises when resource use is sanctioned by professional staff who have no formal budgeting responsibility. A solution might be the allocation of budgets to organisational levels of clinical work, such as specialties. There would again be the problem of identifying a suitable individual or group to be responsible for a budget which encompassed a range of disciplines and functions. For example, would it be feasible for a clinician to manage a specialty budget incorporating nursing services for that specialty over which he had little control? There are difficulties in classifying resources by specialty, particularly when specialties do not correspond exactly with wards. Nursing establishments, for example, are usually determined for wards. Information regarding the consumption of other resources (such as drugs or pathology tests) by patients in different specialties is generally not available, though recent specialty costing experiments (26) have indicated that many of the basic data exist and that modifications to existing information systems may be possible at little extra cost. Whilst evidence to the Royal Commission (16) came down firmly in favour of specialty budgets, the policy of the DHSS is still not clear. The use of specialty costs in the formulation of specialty budgets requires much further scrutiny of the consequences of variations in case-mix within specialties resulting from the particular clinical interests of individual consultants.

Opinion about the role of clinicians as budget holders is divided (27). There is little doubt that the general level of cost-consciousness amongst clinicians is increasing, but there are many who see their active involvement in cost containment conflicting with the principle of clinical freedom. A major problem is the determination of those resources over which clinicians have direct control and for which they might assume budgetary responsibility. Of particular interest is the CASPE (Clinical Accountability, Service Planning and Evaluation) research programme (28) which is investigating the involvement of selected clinicians in the formulation of 'service planning agreements' and the subsequent determination of clinical budgets. Evaluation of these experiments may well determine whether clinical budgeting is possible on a broader scale in the NHS.

The need for financial advice to budget holders at unit level is stressed in the recent circular on the future structure and management of the NHS (29). It is suggested that this be provided

by District treasurers 'through improved financial information systems'. During the last decade a substantial amount of research effort has been expended on financial information systems in the NHS, yet little reward is evident. A clear policy on the development of such systems is necessary and a means of co-ordinating the various research initiatives mentioned earlier is essential. Of paramount importance is that such a policy should be consistent with policies for the development of other related information systems (manpower, patient activity), which should be part of a clearly defined strategy for the development of NHS information systems in general. But improvements in information alone will not lead to closer integration of planning and resource allocation. Changes in attitude are also necessary. At present the costing of plans and the setting of budgets is an activity largely restricted to the purview of treasurers. But as Williams (23) has pointed out:

> once budgeting is openly and inextricably intertwined with objective setting, priorities, performance targets ..... it is essentially a multi-disciplinary process.

9. Conclusions

The evidence of the last decade indicates that a hierarchial system of management and planning, with the centralisation of ultimate authority, has not been effective. There are several reasons why this should be so. First, the functioning of the NHS, which might be likened to a set of services operating independently, has yet to be reconciled in practice with the formal power and responsibility of central government. Second, the unique nature of clinical freedom is not compatible with theories of corporate management. Third, basic knowledge to enable objective statements of the population's needs for health services, or to choose rationally between alternative patterns of care, is lacking. Any form of management structure or planning process which does not come to terms with these realities is bound ultimately to founder.

The Relationship Between Central Government and the NHS

The responsibilities of the Secretary of State for Social Services in relation to health are of mythical proportions; the notion of his accountability to Parliament is at odds with what really happens. In practice, this is recognised. For instance, when Mr. Patrick Jenkin outlined government policy on the NHS on 23 July 1980 in the House of Commons, his statement that: 'I want the new authorities to enjoy considerable autonomy in managing their affairs' was greeted with enthusiasm by the House (1). Parliament has tried to re-exert its control over the executive by establishing select committees, though the practical value of such bodies is limited by the small amount of administrative support available to probe and follow up issues. The main difficulty is that the convention of ministerial responsibility prevents officials from revealing even to MPs what goes on within Whitehall (2).

The Royal Commission expressed a sense of unease about the way in which central government controls the NHS, which led it to consider how the direct involvement of the DHSS in NHS matters could be reduced. An independent observer has recently posed the question of:

> why there is a lack of purposeful direction, and whether ... the failure on the part of the machinery of government may not be a result of an ineffective linkage between two quite different types of body, a Department of State manned by civil servants rooted in a proud tradition of central government service, and the NHS authorities lacking an apex to their service structure...(3)

Other commentators have advocated the establishment of an independent development agency (4) or an advisory authority (5) in recognition of the fact that the NHS lacks a proper management apex. The uneasy relationship between the DHSS and the operating authorities of the NHS is not surprising given the 'highly restricting and artificial conventions within which civil servants are obliged to work' (6), factors which are not particularly relevant to those who manage and provide services in the NHS.

The decision to introduce a managerial system of planning which established formal links between central government and the operating authorities of the NHS was taken by Sir Keith Joseph, Secretary of State for Social Services in the 1970-74 conservative government. Since then, there have been two changes of government (in 1974 and 1979) and three social services secretaries, Mrs. Castle (1974-6), Mr. Ennals (1976-9) and Mr. Jenkin (since 1979). The planning system was still under development when Mr. Jenkin took over. His decision to simplify planning is consistent with current policy to reduce administration in the NHS and to increase local decision making. Two further reasons, however, might be inferred from a report in July 1980 of the Select Committee on Social Services which recommended that:

> the DHSS should give high priority to developing its capacity for devising coherent policy strategies for all the areas for which the Secretary of State is responsible. (7)

and:

> if unpopular decisions have to be taken to reduce the level or scale of services, as the result of the operation of the cash limits system, ministers must take responsibility for the implementation of their policies and their effects on services. (8)

These recommendations imply that the DHSS lacks a coherent strategy, and that ministers would prefer protests about cuts in services to focus on local decision makers rather than on the government. This reflects the different interests of those concerned with the politics of central government and those who have to manage and provide services.

Is any change in the essential relationship between central government and the NHS possible? The current conservative government has initiated changes in the administrative structure of the NHS - though seemingly without altering the basic relationship between central government and the NHS. But, there can be little doubt that simple structural reform will not in itself resolve fundamental problems - an observation made before the 1974 reorganisation (9) which has been justified by the evidence of the last decade. The force of the doctrine of ministerial accountability to Parliament prevents delegation in practice, despite stated intentions to reduce the amount of government interference in the management of local services. The right balance has yet to be found between central control and local freedom.

The role which the DHSS has assumed in policy making and planning is of particular relevance to its relationship with the

NHS. The planning system was designed to enable the delegation of authority, but there has been little sign of any relaxation of detailed controls by the DHSS. There can be no real excuse for the exceptional secrecy which surrounds the departmental planning efforts to the extent that few within the NHS have much knowledge of the process let alone the methods and arguments employed. Yet the NHS is only too well aware of the value of the policies promulgated - for example, the contradictions inherent in priorities for patient groups versus a policy for the geographic distribution of finance. In the short term, there may be some difficulties - or even embarrasment - if the Department's work were open to wider scrutiny, though in the long run a serious dialogue between DHSS and NHS officials and professionals can only be beneficial. The current interface of official meetings and working parties is too restrictive; if a better understanding could be engendered then the quality of planning at national and local levels would improve. The proposed simplification of the centrally promoted planning system creates the opportunity for greater flexibility in local planning or, more likely, for further weakening the impact of national policies.

Changes in central government can result in changes of policies on services. Two recent examples were: the emphasis on prevention credited to the Labour Minister of State for Health, Dr David Owen, a policy which was not mentioned in the conservative government's consultative document issued in December 1979 which seemed to place emphasis on the hospital sector; and, the oscillating policies on hospital size which stress alternately the importance of the centralisation of services in large district general hospitals, then the retention of small hospitals (10). Such changes of approach add to the difficulties of planning and if policies change frequently, then long range planning may seem pointless. The average tenure of a Secretary of State is too short to implement major policies in an organisation as complex and conservative as the NHS. It is long enough to introduce policies, but not to secure them. In this respect, the NHS lacks stable leadership.

A major policy change following the 1979 election was the decision not only to abandon the phasing out of pay beds but also to encourage the NHS to make use of the private sector for medical and other services, such as laundry and catering (11). A labour government would probably reverse this policy; it would discourage an expansion of the private market in health services. The possibility of encouraging private medicine and insurance schemes as a means of providing extra resources for health care should be kept in perspective. Whilst additional resources for the NHS may be generated by such means, within the context of the national economy such additional resources can only be at the expense of some other aspect of the public or private sector. Such provision tends to cater for acute illness in the working population rather than for the chronically ill or handicapped. The sophisticated argument that private resources will release NHS resources for the priority groups pre-supposes a comprehensive policy for health and a planning and control mechanism, neither of which yet exists. It is debatable, however, whether such an approach is desirable. Though the present government is examining the possibility of promoting private medicine and insurance schemes, it should not be allowed

to divert attention from the more fundamental issues of health care priorities and the distribution of resources.

In general, the ebb and flow of party politics involving conflicting dogma is not conducive to the rational development of health services. The notion which has been advanced (4,5) of a body independent of central government acting as a 'head-office' for the NHS might help to resolve the tension between central government and the NHS. It could develop and promote health care policies, act as a focus and channel for NHS views, and ensure appropriate responsiveness to the requirements of central government. The creation of such a body might enable an effective balance between the necessary functions of central government and the realities of providing local services of the kind which is currently lacking.

Clinicial Freedom

Clinical freedom is the cornerstone of medical practice. But the personal bond between a doctor and his patient is not sufficient to ensure that services will be developed which are responsive to the health needs of populations, for two main reasons.

First, it is obvious that resources are finite and that expenditure on one patient necessarily denies treatment for others (since experience suggests that sufficient resources to meet all the needs of the population are not available). Clinicians are used to competing for resources for their patients, though often without admitting that this is precluding the treatment of others. If the overall balance of services were about right, then such laisser faire competition would probably be efficient. But when the balance of services is not right - and national policies over the last decade indicate this to be the position - then experience shows that the prestigious and vocal specialties benefit to the detriment of the low-status (but priority) services. An objective method for adjudicating between competing claims on resources does not exist, and probably never will. The present mechanism involves the derivation of national policies framed against the background of public debate, and the refinement of those policies into local plans in consultation with local interests. Both planning and consultation are essential elements. But the fact remains that the doctrine of clinical freedom does not lend itself to corporate decision making, and it may frustrate any policies however well derived and constructed.

Second, not all health needs result in doctor patient contacts. By definition, if services do not exist (or are inadequate) then patients do not exist (or are limited in numbers). Other services (such as some preventive measures) may not require the intervention of a doctor. A population view of health is therefore essential, which goes much wider than the doctor patient contact and which seeks to identify unmet needs. Epidemiology is the diagnostic tool of population medicine. The development of the community medicine specialty was envisaged as the vehicle to promote a wider perspective, though the promise of that initiative has yet to be fulfilled.

Most clinicians appreciate that resources are finite, and will

be increasingly scarce for the forseeable future. If doctors could be provided with information about the way in which they consume resources in the treatment of their patients, then many might respond by using those resources under their control more efficiently (12). It is questionable, however, whether the response would extend to considering alternative forms of care, or releasing resources for other services.

Planning and Resource Allocation - the limits on knowledge and information

Many services related to the provision of health care fall outside the domain of responsibility of the NHS, a fact which detracts from the comprehensiveness of plans and services. There is an inability to secure co-ordinated policies between departments of state, yet the health care problems which have to be faced require a comprehensive approach. The joint planning and financing initiative by the DHSS was an important step despite its limitations and the ensuing practical difficulties. Effective action is still needed on a wider front to prevent incoherent policies emerging from central government. For example, central government policies on health should recognise the consequences for the NHS of cuts in local government services (in particular, cuts in housing and personal social services). Further, it would be more rational if the assumptions used to plan public expenditure were related more closely to the policies being pursued.

The importance of planning within the NHS cannot seriously be doubted. Despite the uncertain environment created by economic failure and uncoordinated national policies, conscious decisions should be taken on the way in which services are to be developed for the future. Although there are obvious problems, planning is more essential when difficult issues require tackling and when resources become more scarce. The attempts at introducing a formal planning system within the NHS was an important initiative, though the DHSS expected too much too quickly. Nor were the costs of change appreciated.

How might planning in the NHS develop? The DHSS abandoned ten year planning for social services and introduced a much simpler three year planning system designed to link developments with the resource assumptions of PESC. There might be some advantages if planning in the NHS were to follow the same course. First, it would reflect the government's scepticism about detailed forward planning. A distinctive feature of strategic plans which the DHSS sought from the health authorities in 1978 was the detailed forecasts that were requested about the authorities' activities in 1988. Given their subordination to central government in terms of both finance and policy, it was difficult for the authorities to say precisely what the position would be in 1988, especially when they suspected that policies would be modified before then, as indeed they have been (13). They had no experience of bringing about changes on the scale envisaged in the Priorities Document, The Way Forward, and RAWP, and it was information about changes that was being sought. There were great uncertainties about what could be achieved and a reluctance to forecast ten years ahead.

The second advantage for the NHS of three year plans would be

the direct link with the PESC process, which will continue to be important in Whitehall in spite of the undermining of the system by the use of cash limits. PESC takes a three year look ahead on the basis of a range of assumptions. This does not prevent looking further ahead, it merely offers details for the next three years only. Three year planning statements from the NHS might provide a more sound basis for the PESC discussions than the traditional assumptions about demography and more costly medical techniques. The outcome of PESC process would inform the NHS and individual health authorities what funds they are likely to receive in the next three years in the light of their plans. The PESC forecasts would not be certain, but at least they are derived from an established process, the outcome of which is published and interpreted as an expression of the government's intentions. The prospect of possible success in the discussions about levels of public expenditure might provide the much needed stimulus for the operating authorities to take planning seriously. If the linking of health plans and public expenditure decisions at the national level were followed by the same linkage within the NHS (which would be an obvious move), then this would be real progress.

There is a loss of credibility when extensive consultation has taken place on detailed long term plans based on unstable assumptions about policies and finance. It would be more realistic, therefore, if the DHSS were to acknowledge the uncertainties and to make clear what is required from the NHS for central government purposes. Annual planning statements clearly linked to the PESC process would have greater validity than existing NHS plans, which were founded on a rational comprehensiveness perspective which did not reflect adequately the political nature of planning which is more evident locally.

Although there are possible advantages of placing more emphasis on short term plans, these alone would not provide the essential policy framework within which such plans would be produced. The inevitable timescale inherent in any significant change in the pattern of service provision makes the longer term consideration of health care policies inescapable if development is to have any rational basis. The key questions are: how would policies be formulated; and, what steps could be taken to encourage operating authorities to act upon them? The evidence of the last decade clearly indicates that it is not sufficient for policies simply to be promulgated from central government, even when supported by political willpower. The unique nature of clinical freedom, and the significant practical autonomy of the operating authorities, can frustrate any proposed change. To be effective, policies must be translated into agreements between statutory authorities, professional interests, and other pressure groups; though the fact remains that consensus may not always be achievable.

What will ensure that the operating authorities take account of national policies when framing short term plans, or instituting change? In the first place, broad policies will need to be adapted to local situations. The establishment of an independent body (such as a health commission, development agency, or advisory authority) might assist the process of reaching a compromise between national, local, professional and community interests in proposals for local developments, including the run-down of some

services. Neither the original design of the planning system as a control mechanism nor its new role as an information system provides adequate scope for reconciling national needs with local aspirations. Explicit sanctions such as disbanding authorities, or using the power of financial allocations (as used by the Department of the Environment to exert control over miscreant local authorities) are likely to be self-defeating in the long term. More gentle measures such as preferential funding for particular developments, which would be possible if three year plans were linked to the PESC and financial distribution processes at national and regional levels, might prove more successful.

Our examination of strategic plans over the last decade illustrates the practical difficulties of implementing national policies. Planned service developments continue to reflect the traditional importance of the acute hospital sector. The constraints on resources available to the NHS undoubtedly limits what might be achieved for neglected groups such as the elderly, the handicapped, and the mentally ill; but plans show that these groups do not receive the prominence they deserve. It is difficult to envisage how the planning for such priority groups will be facilitated by the reformed administrative structure which places emphasis on local autonomy, and is bound to add to the administrative difficulties of collaboration and joint planning which are essential if comprehensive plans are to be produced.

We have highlighted the issues raised in the plans of the Thames Regions because they need to be resolved in the context of the NHS as a whole. The kernel of the problem is the presence of numerous teaching institutions in inner London which under the present system of financing has the paradoxical effect of penalising the provision of non-acute services, as well as denying services elsewhere in the country. The problem is not solely concerned with teaching students since service provision and teaching must go hand in hand. It is a problem which the University of London, and the DHSS representing the wider interests of the NHS, need to solve jointly. An obvious, though tactically most difficult, solution is to transplant one or more under-graduate schools into the provinces.

The attempt by Regions to produce strategic plans was invaluable in pointing to shortcomings in knowledge and methodology which limit the effectiveness of any scheme of planning. The arbitrary choices of population bases and the crude attempts at judging the need for different services can have dramatic implications in terms of the scale of changes identified. The difficulties of translating service policies into physical terms highlight the inadequacies of manpower planning expertise, and the shortcomings of financial information. In the light of the considerable efforts which have been channelled into constructing those plans, which provide a bench-mark of the state of the art, what is required now is an assessment of existing knowledge leading to a coordinated programme of research aimed at enabling practical improvements. If the DHSS cannot provide the necessary coordination of effort, then in the absence of any other coordinating mechanism Regions should join forces to take up the challenge.

Over the last decade pressures to redress the traditional patterns of resource distribution have reached a point where an

explicit policy to re-distribute finance geographically has been formulated. The implementation of this policy has been constrained by the total level of resources being distributed. Considerable efforts at national level and within the NHS have been devoted to deriving financial allocation formulae which have only been concerned with allocation finance geographically, not with how such allocations might be translated into services. Indeed, as we have already noted, there has been no reconciliation between the national policy on financial allocation and policies for the development of particular services.

Separate formulae for determining capital and revenue allocations have been derived, though emphasis has tended to focus on the latter. The arbitrary distinction between capital and revenue expenditure, in conjunction with inflexible regulations about the transfer and carry-over of allocations, distort what should be a more realistic perspective about the use of financial resources in their totality. The formulae have been based on simple measures which could readily be quantified across the NHS. Local circumstances relevant to service planning and budget setting decisions could not be accommodated within such formulae. This mechanistic approach has detracted from the role of local planning and management. If the government's policy to devolve decision making is to become a reality, then such formulae should be no more than one of a number of sign-posts indicating the direction of change.

Decisions about the pace at which financial targets produced by the formulae would be achieved have been political in nature. The uncertainty from one year to the next about the total volume of resources being distributed has cast further doubt over whether the cash limits ultimately set would ever converge on the theoretical targets. Against the background of a service which has a considerable inertia, and which requires funding from one year to the next, such uncertainties have not facilitated rational change.

Given the absence of fundamental knowledge, particularly when it relates to the need for change, formulae involving arbitrary factors will inevitably be discredited and defended. Unfortunately, this protracted process which has spanned the last decade has obscured the real issue which is: the need for policies on the development and deployment of services leading to the corresponding allocation of finance. The uneven geographical distribution of services throughout the NHS is undisputed, but a policy simply to redress financial inequalities (assuming such a policy can be expressed in practical terms) will not in itself ensure that service deficiencies are made good.

With the future role of Regions not yet clear, there has been some suggestion that allocations might be made directly from the DHSS to district health authorities, with Regions simply controlling the cash limits. Such an approach might appear more equitable in view of the gross differences in methods which Regions have used to determine sub-Regional allocations. But it would inevitably result in allocations being made which were less sensitive to local circumstances, and the gulf between resource allocation and service planning would widen. Such inadequacies can be remedied only by linking planning and financing more closely, as we have described with our notion of how a system of three year planning could develop.

One positive aspect of the debate about resource allocation has been the highlighting of the inadequacy of general financial management. This is a problem rooted in the lack of adequate information. The absence of systematic budgetary procedures (as commented upon by Perrin in evidence to the Royal Commission) is of vital importance, for ultimately the implementation of any policies or plans requires the setting and management of appropriate budgets. A clear picture of current budgetary procedures and the methods by which budgets are set is lacking. The process is mystifying to the uninitiated, though there is some justification for the belief that budgets continue to be set on an incremental basis (last year's level plus an increase for inflation) in the majority of cases irrespective of any health care plans.

A major weakness of district planning teams (formerly health care planning teams) was their lack of integration with the budgetary process. Their work can be effective only if they have influence over the distribution of finance, and promote the efficient use of resources. In this respect, the notion of clinicians controlling budgets is a promising step forward, but a number of substantial organisational problems have yet to be resolved, and unless there is a major change in attitudes it seems unlikely that a majority of clinicians would be prepared to participate. If this approach could be extended to enable planning teams to manage budgets set on a client group basis then this might secure more effective local planning. Such initiatives must, however, wait for improved financial information systems.

References

CHAPTER 1

1. Foot M. (1975) Aneurin Bevan Volume 2, p. 153. (Granada, London).
2. Mackintosh J.P. (1977) The Government and Politics of Britain Fourth edition, p. 175. (Hutchinson, London).
3. Kellner P. and Crowther-Hunt (1980) The Civil Servants (Macdonald, London).
4. Department of Health and Social Security (1979) Patients First (HMSO, London).
5. Regional Chairmen's Enquiry into the working of the DHSS in relation to Regional Health Authorities (1976), paragraph 102. (DHSS, London).
6. Royal Commission on the National Health Service (1979) Report. Cmnd 7615, paragraph 19.44 (HMSO, London).
7. Reference 4 above, p.5.
8. The Government's Expenditure Plans 1980-81 to 1983-84 (1980) Cmnd 7841 (HMSO, London).
9. The Times, 9 May 1980.
10. Robinson A. (1978) Parliament and Public Spending, p.156. (Heinemann, London).
11. Reference 4 above, p.2.
12. Birch A.H. (1964) Representative and Responsible Government, p.245. (George Allen & Unwin, London).
13. Reference 1 above, p.118.
14. Parston G. (1980) Planners, Politics and Health Services, p.16. (Croom Helm, London).
15. Department of Health and Social Security (1972) Management Arrangement for the Reorganised National Health Service, p.46. (HMSO, London).
16. Rose R. (1974) Politics in England Today, p.112. (Faber, London).
17. Reference 2 above, p.172.
18. The Sunday Times Magazine, 27 April 1980.
19. Reference 12 above, p.243.
20. The Crossman Diaries edited by A. Howard (1979), pp.592-3. (Methuen, London).
21. First Report from the Select Committee on Procedure, Session 1977-78 HC588-I, p. viii. (HMSO, London).
22. Reference 12 above, p.140.
23. Stacey F. (1975) British Government 1966-1975 pp. 30-32. (Oxford University Press).
24. Reference 21 above, Appendix D.
25. Reference 10 above, p.154.
26. The Guardian, 25 January 1980.
27. The Times, 25 March 1980.
28. Central Policy Review Staff (1975) A Joint Framework for Social Policies (HMSO, London).
29. Moser C. (1980) Statistics and Public Policy J.R. Statist Soc.A., 143, 1-31.
30. Mackintosh J.P. (1977) The British Cabinet Third Edition, p.519. (Stevens, London).
31. Sedgemore B. (1980) The Secret Constitution, p.27. (Hodder and Stoughton, London).
32. Reference 30 above, p.533.
33. Reference 20 above, p.223.

34. Ibid., p.662.
35. H.M. Treasury (1972) Public Expenditure White Papers Handbook on Methodology p.6. (HMSO, London).
36. Glennerster H. (1975) Social Service Budgets and Social Policy. (George Allen & Unwin, London).
37. Department of Health and Social Security (1976) Sharing Resources for Health in England (HMSO, London).
38. Reference 1 above, p.263.
39. Reference 8 above, p.106.
40. Department of Health and Social Security (1976) Priorities for Health and Personal Social Services in England (HMSO, London).
41. Department of Health and Social Security (1977) The Way Forward (HMSO, London).
42. Ziman J. (1968) Public Knowledge: The Social Dimension of Science (Cambridge University Press).
43. Banks G.T. (1979) Programme Budgeting in the DHSS p.154, in T.A. Booth (editor) Planning for Welfare. (Blackwell, Oxford).
44. Reference 40 above, p.78.
45. Department of Health and Social Security (1972) National Health Service Reorganisation: England Cmnd 5055, p.32. (HMSO, London).
46. Wright M. (1979) 'Planning and Controlling Public Expenditure' in T.A. Booth (editor) Planning for Welfare. (Blackwell, Oxford).
47. Treasury and Civil Service Committee 1979-80. HC450
48. The Times, 12 May 1980.
49. Haywood S. and Alaszewski A. (1980) Crisis in the Health Service. (Croom Helm, London).
50. Reference 6 above, paragraph 19.29.
51. Ibid., paragraph 19.31.
52. Reference 2 above, p.163.
53. Ibid.
54. Ibid., p.176.

CHAPTER 2

1. Owen D. (1976) In Sickness and In Health, p.9. (Quartet Books, London).
2. Regional Chairmen's Enquiry into the working of the DHSS in relation to Regional Health Authorities (1976), paragraph 7. (DHSS, London).
3. Michael J. (1979). The Politics of Secrecy, p.6. (National Council for Civil Liberties, London).
4. Chapman L. (1979). Your Disobedient Servant, p.130. (Penguin, Harmondsworth).
5. Department of Health and Social Security (1972). Management Arrangements for the Reorganised National Health Service. (HMSO, London).
6. Particularly useful reports from the Expenditure Committee were the Ninth and Eleventh Reports 1976-77 (HC466 and HC535) and the Eighth Report 1977-78 (HC600)
7. Klein R. Priorities and the problems of planning. Brit. Med. J, 22 October 1977, 1096-7.
8. The Crossman Diaries edited by A. Howard (1979) p.465. (Methuen, London).
9. Stacey F. (1975) British Government 1966-1975, p.85. (Oxford University Press).
10. See discussion in Brown R.G.S. and Steel D.R. (1979) The Administrative Process in Britain Second Edition (Methuen, London).
11. Reference 5 above, Appendix 2.
12. Reference 2 above, paragraph 148.
13. Reference 5 above, Appendix 2
14. Brown R.G.S. (1979) Reorganising the National Health Service, p.187. (Blackwell, Oxford).
15. Watkin B. (1978) The National Health Service: The First Phase 1948-1974 and After, p.150. (George Allen & Unwin, London).
16. Reference 2 above, paragraphs 150-1.
17. Reference 3 above.

18. Department of Health and Social Security (1976) The NHS Planning System (DHSS, London).
19. Reference 2 above, paragraph 247.
20. Ibid.
21. Reference 5 above, Appendix 2.
22. Eleventh Report from the Expenditure Committee, 1976-77 HC535, Volume 2 (Part 1), p.338. (HMSO, London).
23. Reference 2 above, paragraphs 195-196.
24. Reference 2 above, paragraph 71.
25. Reference 22 above, p.339.
26. Reference 22 above, p.381.
27. Razzell E.J. (1978) Policy Analysis: The DHSS Approach. Mimeograph.
28. Ninth Report from the Expenditure Committee, 1976-77 HC466, p.101. (HMSO, London).
29. Department of Health and Social Security The 1978 National Programme Budget: A Description of the Methodology Underlying the Tables in HC(78)6. Undated mimeograph.
30. Banks G.T. (1979) Programme Budgeting in the DHSS p.156, in T.A. Booth (editor) Planning for Welfare. (Blackwell, Oxford).
31. Ibid., p.171.
32. Report of the Committee on the Civil Service (1968) Cmnd 3638. (HMSO, London).
33. Reference 18 above.
34. Department of Health and Social Security (1976) Priorities for Health and Personal Social Services in England (HMSO, London).
35. Department of Health and Social Security (1976) Sharing Resources for Health in England (HMSO, London).
36. Reference 22 above, p.381.
37. Booth T.A. (1979) Local Authority Forward Planning p.142 in T.A. Booth (editor) Planning for Welfare. (Blackwell, Oxford).
38. Department of Health and Social Security (1979) Patients First, paragraph 36 (HMSO, London).
39. Kellner P. and Crowther Hunt (1980) The Civil Servants, p.49. (Macdonald, London).
40. Department of Health and Social Security (1980) Health Service Development: Structure and Management HC(80)8, paragraph 40.
41. Reference 38 above, paragraph 38.
42. Pethybridge F. (1978) The Case for a National Health Service Advisory Authority. Mimeograph.
43. Region to pave way for national inspectors Health and Social Service Journal, 15 August 1980.
44. Reference 40 above. On 22 May 1980, Mr Jenkin gave the following evidence to the Social Services Committee:
In the long stay field, the health advisory service has a role in assessing the quality of care and in making recommendations about the patterns of care in order to achieve greater efficiency and in order to maintain and improve the quality of care. I have always been attracted by the idea we floated in the document "Patients First", the idea of a more general monitoring role of an inspectorate kind to monitor management efficiency, a management advisory service for the Health Service. Maybe when the simplification of the structure has taken place we may be able to launch an experiment on those lines in order to try to have a more effective system of monitoring the quality of management and therefore efficiency.
(Third Report from the Social Services Committee, Session 1979-80 HC702-2,pp.105-6)

CHAPTER 3

1. National Health Service Reorganisation: England; (HMSO, London); 1972.
2. Department of Health and Social Security (1972) Management Arrangements for the Reorganised NHS; (HMSO, London).
3. Department of Health and Social Security (May 1972) National Health Service Reorganisation: Consultative Document; (unpublished).
4. Department of Health and Social Security (1974) Democracy in the NHS: Membership of Health Authorities; (HMSO, London).

5. Department of Health and Social Security (1976) Priorities for Health and Personal Social Services in England: A consultative Document; (HMSO, London).
6. Jones D.R. and Masterman S.; NHS Resources: Scales of Variation; Brit. J. prev. soc. Med, (1976), 30, 244-250.
7. The NHS Planning System; (DHSS, June 1976).
8. Financial Information Project: First Research Report (1980); (West Midlands RHA).
9. Department of Health and Social Security (1977) Priorities in the Health and Social Services: The Way Forward; (HMSO, London).
10. Royal Commission on the National Health Service (1978). The Working of the National Health Service: Research Paper No. 1; (HMSO, London).
11. Royal Commission on the National Health Service (1978) Management of Financial Resources in the NHS: Research Paper No.2; (HMSO, London).
12. Department of Health and Social Security (1979) Patients First (HMSO, London).
13. Making Sense of the Health Service in The Sunday Telegraph 12 March 1978.
14. The Times, 23rd July,1980.
15. The Health Services Management Centre at Birmingham University examined planning at the Regional level in West Midlands RHA.
The Nuffield Centre for Health Service Studies examined planning at the Area level in Dorset AHA and The City and East London AHA(T).
The Health Services Management Centre at Leicester Polytechnic examined planning at District level in two Districts in the East Anglian RHA.
A coordinated overview of the three projects was to be prepared by Professor Wilcocks at Nottingham University but has yet to be produced.
16. Review of the NHS Planning System: DHSS Proposals SGP(80)3 (April 1980), PPU4 (unpublished).
17. Department of Health and Social Security Working Party on Collaboration Between the NHS and Local Government: Report on its Activities to the end of 1972; (HMSO, London).
18. Norton A. and Rogers S.; (1979) Research Report on Collaboration Between Local Authorities and Health Authorities for the Nuffield Provincial Hospitals Trust (unpublished).
19. Banks G.T. (1979) Programme Budgeting in the DHSS in Planning for Welfare, Ed. T A Booth (Blackwell).
20. Forsyth G. and Varley R. (1980). Health and the Inner-city Partnerships: An Experiment in Collaboration in Problems and Progress in Medical Care 13 series (OUP for the Nuffield Provincial Hospitals Trust).
21. Department of the Environment (1977) Policy for the Inner Cities Cmnd 6845 (HMSO, London).

CHAPTER 4

1. The NHS Planning System; (DHSS, June 1976).
2. McKeown T. (1976) The Role of Medicine: Dream, Mirage, or Nemesis? (The Nuffield Provincial Hospitals Trust).
3. Cochrane A.L. (1971) Effectiveness and Efficiency (OUP for the Nuffield Provincial Hospitals Trust).
4. Ashford J.R. (1977) Planning Local Health Services in Framework and Design for Planning; (OUP for the Nuffield Provincial Hospitals Trust).
5. Patterns for Uncertainty: Planning for the Greater Medical Profession (1979); (OUP for the Nuffield Provincial Hospitals Trust).
6. Financial Information Project: First Research Report (1980); (West Midlands RHA).
7. An approach to Integrating Planning and Resource Allocation (1979); (West Midlands RHA).
8. Royal Commission on the National Health Service (1978) The Working of the National Health Service: Research Paper No.1; (HMSO, London).

CHAPTER 5

1. Yudkin J.S. Changing Patterns of Resource Allocation in a London Teaching District; Brit. Med. J. 2, 1212.

2. In April 1976 the City of East London AHA(T) formally issued a consultative paper proposing the closure of the London Jewish Hospital. All respondents accepted the proposal except: the Tower Hamlets CHC, Ian Mikardo MP, and the Jewish Liaision Committee who recommended the proposal be put to the Secretary of State. In July 1976 the proposal was submitted from the AHA to the Secretary of State.
On 2nd May 1978 the note of a meeting between DHSS, Region, Area and District representatives and Ian Mikardo and representatives of the Jewish community, produced by the DHSS recorded that: "the meeting stemmed from the Minister's consideration of the closure proposal for the London Jewish Hospital and his discussions with Mr. Mikardo on the possible future use of the hospital by the Jewish community".
A letter dated 21st July 1978 from the NE Thames RHA Chairman to Mr. Ennals drew attention to the number of proposals for closure which were awaiting the decision of the Secretary of State. One such proposal was to close the London Jewish Hospital then quoted as costing £1,024,900 (1978/79 prices) for 40 beds.
A letter dated 2nd January 1980 from the secretary of the Tower Hamlets CHC to Dr. Vaughan, Minister of Health, drew attention to the delay over the decision and asked that the District be relieved of wasteful expenditure. (The hospital had been closed temporarily to meet cash limits but maintaining security for the building was costing £750 per week).
3. Lambeth's NHS Cuckoos New Society 28 February 1980, 448-449.
4. The Impending Crisis of Old Age: A Challenge to Inginuity (1980) (OUP for for the Nuffield Provincial Hospitals Trust).
5. SE Thames RHA (April 1978) Strategies and Guidelines for care of the Elderly People.
6. Department of Health and Social Security (1975) Better Services for the Mentally Ill, Cmnd 6233 (HMSO, London).
7. SE Thames RHA (December 1978) Strategies and Guidelines for the Development of Services for Mentally Ill People.
8. Department of Health and Social Security (1971) Better Services for the Mental Handicapped Cmnd 4863 (HMSO, London).
9. SE Thames RHA (November 1978) Strategies and Guidelines for the Development of Services for the Mentally Handicapped People.
10. Fit for the Future: Report of the Committee on Child Health Services Cmnd 6684 (HMSO, London).
11. Ashford J.R. (1980) Trends in Maternity Care in England and Wales 1963-1977 in Problems and Progress in Medical Care 13 Series (OUP for the Nuffield Provincial Hospitals Trust).
12. Ashford J.R. (1979) Perinatal Mortality as an Indicator of the Effectiveness of Medical Care: An Analysis of the Variations Between the Area Health Authorities of England and Wales 1974-1977 (unpublished).
See also Chalmers I et al Obstetric Practice and Outcome of Pregnancy in Cardiff Residents 1965-1973 Brit. Med. J. 1976, I, 735-738.
13. Ellis J. Medical Education in London Brit. Med. J 20 March 1980, 923-927.
14. London Medical Education: a New Framework (1980), University of London.
15. Flowers Report Shelved by London University; Times Higher Education Supplement 27 June 1980.
16. London Health Planning Consortium (1979) Acute Hospital Services in London (HMSO for the DHSS).
17. London Health Planning Consortium (February 1980) Towards a Balance: a framework for acute hospital services in London reconciling service with teaching needs.

CHAPTER 6

1. Forsyth G. and Varley R. (1980) Health and the Inner-city Partnerships: An experiment in Collaboration in Problems and Progress in Medical Care 13 Series (OUP for the Nuffield Provincial Hospitals Trust).
2. Letter to Area Administrators dated 24 January 1979 from Regional Administrator Trent RHA; Discussion Paper on Future Bed Requirements for Basic Acute Specialties.

3. Rudge J.F. and Richards B.W. Strategic Planning of Acute Beds by Specialty; British Medical Journal 10 November 1979.
4. Butts M.S. and Ashford J.R. (1977) A Framework for Planning Hospital Services in Framework and Design for Planning (OUP for the Nuffield Provincial Hospitals Trust).
5. Department of Health and Social Security (1975) Better Services for the Mentally Ill; (HMSO, London).
6. Department of Health and Social Security (1971) Better Services for the Mentally Handicapped; (HMSO, London).
7. Ashford J.R. (1980) Trends in Maternity Care in England and Wales 1963-1977 in Problems and Progress in Medical Care 13 Series (OUP for the Nuffield Provincial Hospitals Trust).
8. The Times 16 November,1980.
9. Ashford J.R., Ferster G., and Makuc D.M. (1973) An Approach to Resource Allocation in The Future and Present Indicatives; (OUP for the Nuffield Provincial Hospitals Trust).
10. Fit for the Future: Report of the Committee on Child Health Services Cmnd 6684 (HMSO, London).
11. Financial Information Project: First Research Report (West Midlands RHA, 1980).
12. Patterns for Uncertainty? Planning for the Greater Medical Profession (1979); (OUP for the Nuffield Provincial Hospitals Trust).
13. Department of Health and Social Security (May 1980) Hospital Services: The Future Pattern of Hospital Provision in England.

CHAPTER 7

1. Ministry of Health (1962) A Hospital Plan for England and Wales Cmnd 1604 (HMSO, London).
2. Department of Health and Social Security (1970) National Health Service: The Future Structure of the National Health Service (HMSO, London).
3. Department of Health and Social Security (1970) Circular 3/70 to RHB Chairmen.
4. West P. (1973) Allocation and Equity in the Public Sector : the hospital revenue allocation formula; Applied Economics,5,153.
5. Department of Health and Social Security (1975) First Interim Report of the Resource Allocation Working Party: Allocations to Regions in 1976/77 August 1975 (unpublished)
6. Department of Health and Social Security (1976) Sharing Resources for Health in England; Report of the Resource Allocation Working Party (HMSO, London).
7. Radical Statistics Health Group (1977) RAW(P) Deals.
8. Buxton M.J., and Klein R.E. (1978) Allocating Health Resources: a commentary on the report of the Resource Allocation Working Party Royal Commission on the NHS Research Paper No. 3 (HMSO,London).
9. Scottish Home and Health Department (1977) Scottish Health Authorities Revenue Equalisation Report of the Working Party on Revenue Resource Allocation (HMSO,London).
10. HC(76)29.
11. HC(78)12.
12. Department of Health and Social Security (1979) Health Service Planning in England. Letter to Regional Administrators, March 1979.
13. Cuninghame-Green R.A. (1977) Metaphysics versus Management; Paper presented at West Midlands RHA Seminar on 'Sharing Resources for Health' 27 January 1978 (mimeo).
14. Magee C.C. and Osmolski R.J. (1978) A Comprehensive System of Managment Information for Financial Planning Decision Making and Control in the Hospital Service Technical paper prepared for the Royal Commission on the NHS: Centre for Industrial Economics and Business Research, University of Warwick.
15. Ashford J.R and Butts M.S. (1979) The Structure of Hospital In-patient Costs in Mixed Communications (OUP for the Nuffield Provincial Hospitals Trust).
16. Jones F.A. (1976) The London Hospitals Scene BMJ,2,1046-9.

17. Forster D.P. (1977) Mortality, Morbidity and Resource Allocation Lancet, May 7 1977.
18. SE Thames RHA (1977) unpublished mimeo.
19. Geary K. (1977) Technical Deficiencies in RAWP. BMJ 1977, 1, 1367.
20. West R. (1978) Bed Usage and Disease Specific Mortality within ICD Chapters. Journal of Epidemiology and Community Health 1978, 32, 38-40.
21. Palmer S.R. et al (1980) Randomness in the RAWP formula: the reliability of mortality data in the allocation of NHS revenue. Journal of Epidemiology and Community Medicine 1980, 34, 212-216.
22. Barr A and Logan R.F.L. (1977) Policy Alternatives for Resource Allocation. Lancet, May 7 1977.
23. Kilpatrick S.J. (1963) Mortality Comparisons in Socio-economic Groups Applied Statistics 1963,12,65.
24. Ferrer H.P. et al (1977) The Use of Mortality Data in the Report of the RAWP Public Health,1977,91,289.
25. Palmer S.R. et al (1979) Mortality Indices in Resource Allocation Community Medicine,1,275-281.
26. Department of Health and Social Security (1978) Letter VE 98/11 to Regional Administrators, 6 April 1978.
27. West P.A. et al (1980) Sharing fairly in the NHS: the effect of imperfect cost data in RAWP. Hospital and Health Services Review October 1980, 330-334
28. Creese A.L. et al (1978) NHS Piorities and RAWP BMJ,2,1446-7.
29. University of York (1975) Institute of Social and Economic Research: various Reports for Department of Health and Social Security.
30. Lowe R. (1978) How to solve the clash over medical education. Times Higher Educational Supplement 30th June 1978.
31. Department of Health and Social Security (1979) NHS Resources: Government's Fair Shares Plan is on Target. Allocations to RHAs 1979/80 no. 79/36, 5 February 1979.
32. Department of Health and Social Security (1978) Letter to Regional Administrators 13 April 1978.
33. Department of Health and Social Security (1978) Letter H3/H264/14B to Regional Administrators 28 November 1978.
34. Department of Health and Social Security (1980) Report of the Advisory Group on Resource Allocation. (unpublished).
35. Wild D.W. (1980) RAWP: the need for further discussion. Hospital and Health Services Review. October 1980, 337.
36. Department of Health and Social Security (1980) Letter V/E105/39 to Regional Administrators 7 March 1980.
37. HC(77)6
38. Department of Health and Social Security (1978) Letter J1/H234/41 to Regional Administrators 13th April 1978.
39. Department of Health and Social Security (1979) Letter J1/H234/67 to Regional Administrators 9th April 1979.
40. Department of Health and Social Security (1980) Letter J1/H234/74 to Regional Administrators 19th March 1980.

CHAPTER 8

1. Cuninghame-Green R.A. (1978) Can Judgement and Formulae be Reconciled? Paper presented at West Midlands RHA seminar on Sharing Resources for Health 27 January 1978.
2. Fox P.D. (1978) Managing Resources English Style in By Guess or By What: Information Without Design in the NHS (OUP for the Nuffield Provincial Hospital Trust).
3. West Midlands RHA (1977) Interim Report of the Technical Support Group; paper presented to the Capital and Revenue Targets Working Party, November 1977.
4. Forsyth G. and Varley R. (1978). Resource Allocation Sub-Regionally: the Impact in the North Western RHA. Nuffield Provincial Hospitals Trust. 13th December 1978 (mimeo).
5. Akehurst R.L. and Johnson K.W. (1980) Cross boundary flows of patients: the effect of adjusting sub-regional target revenue allocations for case

mix within the North Western RHA. Hospital and Health Services Review October 1980, 334-336.
6. Ashford J.R and Butts M.S. (1979) The Structure of Hospital In-patient Costs in Mixed Communications (OUP for the Nuffield Provincial Hospitals Trust).
7. Senn S.J. and Shaw H. (1978) Resource Allocation. Some Problems in Applying the National Formula to Area and District Revenue Allocations Journal of Epidemiology and Community Health 1978,32,22-27.
8. Cottrell K.M. (1979) Out-patient Survey of the North Western Region Hospital and Health Service Review December 1979.
9. Ferrer H.P. et al (1977) The Use of Mortality Data in the Report of the RAWP Public Health,1977,91,289.
10. Johnson K.W (1978) Measuring the Need for Non-psychiatric in-patient services - the effect of amalgamating disease categories in the RAWP formula Research report No. 3, April 1978, Regional Statistical Unit, North Western RHA.
11. Akehurst R.L. and Blackburn K. (1979) Geographical Cost Variations in the North Western RHA Hospital and Health Services Review, November 1979, 400-405.
12. Department of Health and Social Security (1980) Assessing Target Allocations within the Thames Regions, Report of a Joint Working Group, (unpublished).
13. Department of Health and Social Security (1978) Letter to Regional Treasurers 26th July 1978.
14. Department of Health and Social Security (1979) Letter to Regional Administrators, 11 April 1979.
15. HN(79)21
16. Royal Commission on the NHS (1978) Management of Financial Resources in the NHS. Research Paper No.2, HMSO.
17. West Midlands RHA (1979) Preliminary Statement: Financial Information Project November 1979.
18. King Edward's Hospital Fund for London (1973) Accounting for Health. Report of a Working Party (Chairman: B Abel-Smith.)
19. Department of Health and Social Security (1979) Information for Planning. Report of the Information sub-group of the Standing Group on NHS Planning (unpublished).
20. Oxford RHA (1978) 2nd Report of the Regional Revenue Advisory Group December 1978.
21. West Midlands RHA (1979) Integrated Planning and Resource Allocation Regional Treasurer's Department mimeo.
22. Cuninghame-Green R.A. (1977) Metaphysics versus Management Paper presented at West Midlands RHA seminar on 'Sharing Resources for Health' 27 January 1978 (mimeo).
23. Williams A. (1978) The Budget as a (Mis-) Information System in Economic Aspects of Health Services, eds. Culyer A.J. and Wright K.G. (Martin Robertson, London).
24. Firth C.M. (1979) Base-year Expenditure Analysis for Programme Budgeting in an RHA. Hospital and Health Services Review January 1979.
25. Steele R. and Gray A.M. (1980) Beyond the Programme Budget: Economics and Resource Planning in the NHS. Hospital and Health Services Review March 1980.
26. Magee C.C. and Osmolski R.J. (1978) A Comprehensive System of Management Information for Planning Decision Making and Control in the Hospital Service Technical paper prepared for the Royal Commission on the NHS: Centre for Industrial Economics and Business Research, University of Warwick.
27. Department of Health and Social Security (1978) Hospital Costing and the Clinician. Harrogate Seminar Report No.1, Economic Advisors Office.
28. Clinical Accountability, Service Planning and Evaluation. DHSS research project based at the Kings Fund College - project coordinator: H.I. Wickings.
29. HC(80)8

CHAPTER 9

1. The Times, 23 July 1980.
2. First Report of the Select Committee on Procedure, Session 1977-78 HC588-I (HMSO, London).
3. Nuffield Provincial Hospitals Trust (1980) Tenth Report.
4. Tether P. (1979) A Development Agency for the National Health Service. (Institute for Health Studies, University of Hull).
5. Pethybridge F. (1978), The Case for a National Health Service Advisory Authority Mimeograph.
6. A remark attributed to a civil servant and quoted in R. Rose (1974) Politics in England Today, p.87. (Faber, London).
7. Third Report from the Social Services Committee Session 1979-80. HC702 (HMSO, London).
8. Ibid.
9. Challenges for Change: Essays on the next decade in the National Health service (1971), (OUP for the Nuffield Provincial Hospitals Trust).
10. Department of Health and Social Security (May 1980) consultation paper on The Future Pattern of Hospital Provision in England.
11. The Lancet, Private Sub-contractors and the NHS, Editorial 23 August,1980.
12. Wickings H.I. (1978) Incentive Budgets and Planning Agreements for Clinical Teams in Hospital Costing and the Clinician, Harrogate Seminar Reports 1, E.A.O., Department Health and Social Security.
13. See, for instance, reference 10. above.